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**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development**

Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression, David Kaye*

Summary

In the present report, submitted in accordance with Human Rights Council resolution 25/2, the Special Rapporteur addresses the use of encryption and anonymity in digital communications. Drawing from research on international and national norms and jurisprudence, and the input of States and civil society, the report concludes that encryption and anonymity enable individuals to exercise their rights to freedom of opinion and expression in the digital age and, as such, deserve strong protection.

* Late submission.

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I. Introduction

1. Contemporary digital technologies offer Governments, corporations, criminals and pranksters unprecedented capacity to interfere with the rights to freedom of opinion and expression. Online censorship, mass and targeted surveillance and data collection, digital attacks on civil society and repression resulting from online expression force individuals around the world to seek security to hold opinions without interference and seek, receive and impart information and ideas of all kinds. Many seek to protect their security through encryption, the scrambling of data so only intended recipients may access it, which may be applied to data in transit (e.g., e-mail, messaging, Internet telephony) and at rest (e.g., hard drives, cloud services). Others seek additional protection in anonymity, using sophisticated technologies to disguise their identity and digital footprint. Encryption and anonymity, today's leading vehicles for online security, provide individuals with a means to protect their privacy, empowering them to browse, read, develop and share opinions and information without interference and enabling journalists, civil society organizations, members of ethnic or religious groups, those persecuted because of their sexual orientation or gender identity, activists, scholars, artists and others to exercise the rights to freedom of opinion and expression.

2. Yet, just as the telephone may be used both to report a crime to the police and to conspire to commit one, so too may the Internet be abused to interfere with the rights of others, national security or public order. Law enforcement and intelligence services often assert that anonymous or encrypted communications make it difficult to investigate financial crimes, illicit drugs, child pornography and terrorism. Individuals express legitimate concerns about how bullies and criminals use new technologies to facilitate harassment. Some States restrict or prohibit encryption and anonymity on these and other grounds, while others are proposing or implementing means for law enforcement to circumvent these protections and access individual communications.

3. In the light of these challenges, the present report examines two linked questions. First, do the rights to privacy and freedom of opinion and expression protect secure online communication, specifically by encryption or anonymity? And, second, assuming an affirmative answer, to what extent may Governments, in accordance with human rights law, impose restrictions on encryption and anonymity? The present report seeks to answer these questions, review examples of State practice and propose recommendations. It does not purport to address every technical or legal question raised by digital technologies, but it identifies important ones for future reporting.

4. In preparing the report, the Special Rapporteur circulated a questionnaire to States, seeking relevant information on their domestic laws, regulations, policies and practices. As of 1 April 2015, 16 States had responded to this request.¹ The Special Rapporteur also issued a call for submissions from non-governmental stakeholders and convened a meeting of experts in Geneva in March 2015. The responses from Governments and the over 30 submissions by civil society organizations and individuals, which are available from the mandate holder's web page, contributed significantly to the preparation of the report.

5. A full review of the Special Rapporteur's activities since the beginning of his term in August 2014 may be found on the mandate holder's web page. This report, the current

¹ Responses were received from Austria, Bulgaria, Cuba, Germany, Greece, Guatemala, Ireland, Kazakhstan, Lebanon, Qatar, Republic of Moldova, Norway, Slovakia, Sweden, Turkey and the United States of America.

mandate holder's first, aims at furthering the work on the challenges to freedom of expression in the digital age.

II. Secure and private communication in the digital age

A. Contemporary encryption and anonymity

6. Modern approaches to private and secure communication draw on ideas that have been with humankind for millennia. The rise of electronic data storage, the Internet and mass data collection and retention made clear that sophisticated means would be needed to protect individual, corporate and government data. As e-mail, instant-messaging, Voice-over-Internet Protocols, videoconferencing and social media moved from niche services to predominant and easily monitored modes of communication, individuals developed a need for security online, so that they could seek, receive and impart information without the risk of repercussions, disclosure, surveillance or other improper use of their opinions and expression.

7. Encryption — a mathematical “process of converting messages, information, or data into a form unreadable by anyone except the intended recipient”² — protects the confidentiality and integrity of content against third-party access or manipulation. Strong encryption, once the sole province of militaries and intelligence services, is now publicly accessible and often freely available to secure e-mail, voice communication, images, hard drives and website browsers. With “public key encryption”, the dominant form of end-to-end security for data in transit, the sender uses the recipient’s public key to encrypt the message and its attachments, and the recipient uses her or his own private key to decrypt them. Encryption may also be used to create digital signatures to ensure that a document and its sender are authentic, to authenticate and verify the identity of a server and to protect the integrity of communications between clients against tampering or manipulation of traffic by third parties (e.g., “man-in-the-middle” attacks). Since the encryption of data in transit does not ensure against attacks on unencrypted data when it is sitting at rest at either endpoint (nor protect the security of one’s private key), one may also encrypt data at rest stored on laptops, hard drives, servers, tablets, mobile phones and other devices. Online practices may also be moving away from the system described here and towards “forward secrecy” or “off-the-record” technology in which keys are held ephemerally, particularly for uses such as instant messaging.

8. Some call for efforts to weaken or compromise encryption standards such that only Governments may enjoy access to encrypted communications. However, compromised encryption cannot be kept secret from those with the skill to find and exploit the weak points, whether State or non-State, legitimate or criminal. It is a seemingly universal position among technologists that there is no special access that can be made available only to government authorities, even ones that, in principle, have the public interest in mind. In the contemporary technological environment, intentionally compromising encryption, even for arguably legitimate purposes, weakens everyone’s security online.

9. Notably, encryption protects the content of communications but not identifying factors such as the Internet Protocol (IP) address, known as metadata. Third parties may gather significant information concerning an individual’s identity through metadata analysis if the user does not employ anonymity tools. Anonymity is the condition of

² See SANS Institute, “History of <http://www.sans.org/reading-room/whitepapers/vpns/history-encryption-730encryption>” (2001).

avoiding identification. A common human desire to protect one's identity from the crowd, anonymity may liberate a user to explore and impart ideas and opinions more than she would using her actual identity. Individuals online may adopt pseudonyms (or, for instance, fake e-mail or social media accounts) to hide their identities, image, voice, location and so forth, but the privacy afforded through such pseudonyms is superficial and easily disturbed by Governments or others with the necessary expertise; in the absence of combinations of encryption and anonymizing tools, the digital traces that users leave behind render their identities easily discoverable. Users seeking to ensure full anonymity or mask their identity (such as hiding the original IP address) against State or criminal intrusion may use tools such as virtual private networks (VPNs), proxy services, anonymizing networks and software, and peer-to-peer networks.³ One well-known anonymity tool, the Tor network, deploys more than 6,000 decentralized computer servers around the world to receive and relay data multiple times so as to hide identifying information about the end points, creating strong anonymity for its users.

10. A key feature of the digital age is that technology changes incessantly to sate user demands. Although the present report refers to contemporary technologies that facilitate encryption and anonymity, its analysis and conclusions apply generally to the concepts behind the current technologies and should be applicable as new technologies replace the old.

B. Uses of the technologies

11. The Internet has profound value for freedom of opinion and expression, as it magnifies the voice and multiplies the information within reach of everyone who has access to it. Within a brief period, it has become the central global public forum. As such, an open and secure Internet should be counted among the leading prerequisites for the enjoyment of the freedom of expression today. But it is constantly under threat, a space — not unlike the physical world — in which criminal enterprise, targeted repression and mass data collection also exist. It is thus critical that individuals find ways to secure themselves online, that Governments provide such safety in law and policy and that corporate actors design, develop and market secure-by-default products and services. None of these imperatives is new. Early in the digital age, Governments recognized the essential role played by encryption in securing the global economy, using or encouraging its use to secure Government-issued identity numbers, credit card and banking information, business proprietary documents and investigations into online crime itself.⁴

12. Encryption and anonymity, separately or together, create a zone of privacy to protect opinion and belief. For instance, they enable private communications and can shield an opinion from outside scrutiny, particularly important in hostile political, social, religious and legal environments. Where States impose unlawful censorship through filtering and other technologies, the use of encryption and anonymity may empower individuals to circumvent barriers and access information and ideas without the intrusion of authorities. Journalists, researchers, lawyers and civil society rely on encryption and anonymity to shield themselves (and their sources, clients and partners) from surveillance and harassment. The ability to search the web, develop ideas and communicate securely may be

³ Proxy services send data through an intermediary, or "proxy server", that sends that data on behalf of the user, effectively masking the user's IP address with its own to the end recipient. Peer-to-peer networks partition and store data among interconnected servers and then encrypt that stored data so that no centralized server has access to identifying information. See, for example, Freenet.

⁴ See OECD, *Guidelines for Cryptography Policy* (1997) <https://www.oecd.org/internet/economy/guidelinesforcryptographypolicy.htm>.

the only way in which many can explore basic aspects of identity, such as one's gender, religion, ethnicity, national origin or sexuality. Artists rely on encryption and anonymity to safeguard and protect their right to expression, especially in situations where it is not only the State creating limitations but also society that does not tolerate unconventional opinions or expression.

13. The "dark" side of encryption and anonymity is a reflection of the fact that wrongdoing offline takes place online as well. Law enforcement and counter-terrorism officials express concern that terrorists and ordinary criminals use encryption and anonymity to hide their activities, making it difficult for Governments to prevent and conduct investigations into terrorism, the illegal drug trade, organized crime and child pornography, among other government objectives. Harassment and cyberbullying may rely on anonymity as a cowardly mask for discrimination, particularly against members of vulnerable groups. At the same time, however, law enforcement often uses the same tools to ensure their own operational security in undercover operations, while members of vulnerable groups may use the tools to ensure their privacy in the face of harassment. Moreover, Governments have at their disposal a broad set of alternative tools, such as wiretapping, geo-location and tracking, data-mining, traditional physical surveillance and many others, which strengthen contemporary law enforcement and counter-terrorism.⁵

III. Encryption, anonymity and the rights to freedom of opinion and expression and privacy

14. The human rights legal framework for encryption and anonymity requires, first, evaluating the scope of the rights at issue and their application to encryption and anonymity; and, second, assessing whether, and if so to what extent, restrictions may lawfully be placed on the use of technologies that promote and protect the rights to privacy and freedom of opinion and expression.

15. The rights to privacy⁶ and freedom of opinion and expression⁷ have been codified in universal and regional human rights instruments, interpreted by treaty bodies and regional courts, and evaluated by special procedures of the Human Rights Council and during universal periodic review. The universal standards for privacy, opinion and expression are found in the International Covenant on Civil and Political Rights, to which 168 States are party. Even for those remaining States that are not bound by it, the Covenant presents at the very least a standard for achievement and often reflects a customary legal norm; those that

⁵ See Center for Democracy and Technology, "'Going Dark' <https://cdt.org/blog/%25e2%2580%2598going-dark%25e2%2580%2599-versus-a-%25e2%2580%2598golden-age-for-surveillance%25e2%2580%2599/> versus a <https://cdt.org/blog/%25e2%2580%2598going-dark%25e2%2580%2599-versus-a-%25e2%2580%2598golden-age-for-surveillance%25e2%2580%2599/> Golden Age for Surveillance'" (2011).

⁶ Article 12 of the Universal Declaration of Human Rights, article 17 of the International Covenant on Civil and Political Rights, article 16 of the Convention on the Rights of the Child, article 22 of the Convention on the Rights of Persons with Disabilities, article 14 of the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, article 8 of the European Convention on Human Rights and article 11 of the American Convention on Human Rights protect the right to privacy.

⁷ Article 19 of the Universal Declaration and the International Covenant on Civil and Political Rights, article 9 of the African Charter on Human and Peoples' Rights, article 13 of the American Convention on Human Rights and article 10 of the European Convention on Human Rights protect freedom of expression.

have signed but not ratified the Covenant are bound to respect its object and purpose under article 18 of the Vienna Convention on the Law of Treaties. National legal systems also protect privacy, opinion and expression, sometimes with constitutional or basic law or interpretations thereof. Several global civil society projects have also provided compelling demonstrations of the law that should apply in the context of the digital age, such as the International Principles on the Application of Human Rights to Communications Surveillance and the Global <http://www.opensocietyfoundations.org/publications/global-principles-national-security-and-freedom-information-tshwane-principles> Principles on National Security and the Right to Information. Although specific standards may vary from right to right, or instrument to instrument, a common thread in the law is that, because the rights to privacy and to freedom of expression are so foundational to human dignity and democratic governance, limitations must be narrowly drawn, established by law and applied strictly and only in exceptional circumstances. In a digital age, protecting such rights demands exceptional vigilance.

A. Privacy as a gateway for freedom of opinion and expression

16. Encryption and anonymity provide individuals and groups with a zone of privacy online to hold opinions and exercise freedom of expression without arbitrary and unlawful interference or attacks. The previous mandate holder noted that the rights to “privacy and freedom of expression are interlinked” and found that encryption and anonymity are protected because of the critical role they can play in securing those rights (A/HRC/23/40 and Corr.1). Echoing article 12 of the Universal Declaration of Human Rights, article 17 of the International Covenant on Civil and Political Rights specifically protects the individual against “arbitrary or unlawful interference with his or her privacy, family, home or correspondence” and “unlawful attacks on his or her honour and reputation”, and provides that “everyone has the right to the protection of the law against such interference or attacks”. The General Assembly, the United Nations High Commissioner for Human Rights and special procedure mandate holders have recognized that privacy is a gateway to the enjoyment of other rights, particularly the freedom of opinion and expression (see General Assembly resolution 68/167, A/HRC/13/37 and Human Rights Council resolution 20/8).

17. Encryption and anonymity are especially useful for the development and sharing of opinions, which often occur through online correspondence such as e-mail, text messaging, and other online interactions. Encryption provides security so that individuals are able “to verify that their communications are received only by their intended recipients, without interference or alteration, and that the communications they receive are equally free from intrusion” (see A/HRC/23/40 and Corr.1, para. 23). Given the power of metadata analysis to specify “an individual’s behaviour, social relationships, private preferences and identity” (see A/HRC/27/37, para. 19), anonymity may play a critical role in securing correspondence. Besides correspondence, international and regional mechanisms have interpreted privacy to involve a range of other circumstances as well.⁸

18. Individuals and civil society are subjected to interference and attack by State and non-State actors, against which encryption and anonymity may provide protection. In

⁸ Human Rights Committee, general comment No. 16 (1988) on the right to respect of privacy, family, home and correspondence, and protection of honour and reputation. See also European Court of Human Rights, factsheets on data protection (http://www.echr.coe.int/documents/fs_data_eng.pdf) and right to protection of one’s image (http://www.echr.coe.int/documents/fs_own_image_eng.pdf).

article 17 (2) of the International Covenant on Civil and Political Rights, States are obliged to protect privacy against unlawful and arbitrary interference and attacks. Under such an affirmative obligation, States should ensure the existence of domestic legislation that prohibits unlawful and arbitrary interference and attacks on privacy, whether committed by government or non-governmental actors. Such protection must include the right to a remedy for a violation.⁹ In order for the right to a remedy to be meaningful, individuals must be given notice of any compromise of their privacy through, for instance, weakened encryption or compelled disclosure of user data.

B. Right to hold opinions without interference

19. The first article of the Universal Declaration of Human Rights recognizes that everyone is "endowed with reason and conscience", a principle developed further in human rights law to include, among other things, the protection of opinion, expression, belief, and thought. Article 19 (1) of the International Covenant on Civil and Political Rights, also echoing the Universal Declaration, provides that "everyone shall have the right to hold opinions without interference". Opinion and expression are closely related to one another, as restrictions on the right to receive information and ideas may interfere with the ability to hold opinions, and interference with the holding of opinions necessarily restricts the expression of them. However, human rights law has drawn a conceptual distinction between the two. During the negotiations on the drafting of the Covenant, "the freedom to form an opinion and to develop this by way of reasoning was held to be absolute and, in contrast to freedom of expression, not allowed to be restricted by law or other power".¹⁰ The ability to hold an opinion freely was seen to be a fundamental element of human dignity and democratic self-governance, a guarantee so critical that the Covenant would allow no interference, limitation or restriction. Consequently, the permissible limitations in article 19 (3) expressly apply only to the right to freedom of expression in article 19 (2). Interference with the right to hold opinions is, by contrast, *per se* in violation of article 19 (1).

20. Commentators and courts have devoted much less attention to the right to hold opinions than to expression. Greater attention is warranted, however, as the mechanics of holding opinions have evolved in the digital age and exposed individuals to significant vulnerabilities. Individuals regularly hold opinions digitally, saving their views and their search and browse histories, for instance, on hard drives, in the cloud, and in e-mail archives, which private and public authorities often retain for lengthy if not indefinite periods. Civil society organizations likewise prepare and store digitally memoranda, papers and publications, all of which involve the creation and holding of opinions. In other words, holding opinions in the digital age is not an abstract concept limited to what may be in one's mind. And yet, today, holding opinions in digital space is under attack. Offline, interference with the right to hold an opinion may involve physical harassment, detention or subtler efforts to punish individuals for their opinion (see CCPR/C/78/D/878/1999, annex, paras. 2.5, 7.2 and 7.3). Interference may also include such efforts as targeted

⁹ See Human Rights Committee
http://tbinternet.ohchr.org/_layouts/treatybodyexternal/download.aspx?symbolno=int%252fcccpr%252fgec%252f6624&lang=en&general
http://tbinternet.ohchr.org/_layouts/treatybodyexternal/download.aspx?symbolno=int%252fcccpr%252fgec%252f6624&lang=en&commentNo=16&generalCommentNo=31 on the nature of the general legal obligation imposed on States parties to the Covenant, and CCPR/C/106/D/1803/2008.

¹⁰ Manfred Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (1993), p. 441.

surveillance, distributed denial of service attacks, and online and offline intimidation, criminalization and harassment. Targeted digital interference harasses individuals and civil society organizations for the opinions they hold in many formats. Encryption and anonymity enable individuals to avoid or mitigate such harassment.

21. The right to hold opinions without interference also includes the right to form opinions. Surveillance systems, both targeted and mass, may undermine the right to form an opinion, as the fear of unwilling disclosure of online activity, such as search and browsing, likely deters individuals from accessing information, particularly where such surveillance leads to repressive outcomes. For all these reasons, restrictions on encryption and anonymity must be assessed to determine whether they would amount to an impermissible interference with the right to hold opinions.

C. Right to freedom of expression

22. The right to freedom of expression under article 19 (2) of the International Covenant on Civil and Political Rights expands upon the Universal Declaration's already broad guarantee, protecting the "freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice". A significant accumulation of jurisprudence, special procedure reporting, and resolutions within the United Nations and regional human rights systems underscores that the freedom of expression "is essential for the enjoyment of other human rights and freedoms and constitutes a fundamental pillar for building a democratic society and strengthening democracy" (Human Rights Council resolution 25/2). The Human Rights Council, the General Assembly and individual States regularly assert that individuals enjoy the same rights online that they enjoy offline.¹¹ The present report will not repeat all the elements of this consensus. In the context of encryption and anonymity, three aspects of the text deserve particular emphasis (see paras. 23–26 below).

23. **Freedom to seek, receive, and impart information and ideas:** In environments of prevalent censorship, individuals may be forced to rely on encryption and anonymity in order to circumvent restrictions and exercise the right to seek, receive and impart information. Some States have curtailed access with a variety of tools. State censorship, for instance, poses sometimes insurmountable barriers to the right to access information. Some States impose content-based, often discriminatory restrictions or criminalize online expression, intimidating political opposition and dissenters and applying defamation and lese-majesty laws to silence journalists, defenders and activists. A VPN connection, or use of Tor or a proxy server, combined with encryption, may be the only way in which an individual is able to access or share information in such environments.

24. It bears emphasizing that human rights law also protects the right to seek, receive and impart scientific information and ideas. The Universal Declaration and the International Covenant on Economic, Social and Cultural Rights protect rights to education and "to share in scientific advancement and its benefits". Encryption and anonymity technologies enable individuals to share in such information in situations where they are otherwise denied, and

¹¹ See, e.g., General Assembly resolution <http://www.ohchr.org/en/issues/digitalage/pages/digitalageindex.aspx68/167>, Human Rights Council resolution <http://daccess-dds-ny.un.org/doc/undoc/gen/g14/082/83/pdf/g1408283.pdf?openelement26/13> and Council of Europe <https://wcd.coe.int/viewdoc.jsp?id=2184807> recommendation CM/Rec (2014) 6 of the Committee of Ministers to member States on a <https://wcd.coe.int/viewdoc.jsp?id=2184807> guide to human rights for Internet users.

they are themselves examples of scientific advancement. Their use empowers individuals to gain access to the benefits of scientific progress that might be curtailed by Government. The Special Rapporteur in the field of cultural rights noted that “the rights to science and to culture should both be understood as including a right to have access to and use information and communication and other technologies in self-determined and empowering ways” (see A/HRC/20/26, para. 19).

25. **Regardless of frontiers:** The major instruments guaranteeing freedom of expression explicitly acknowledge the transboundary scope of the right. Individuals enjoy the right to receive information from, and transmit information and ideas of all kinds to, places beyond their borders.¹² However, some States filter or block data on the basis of keywords, denying access by deploying technologies that rely on access to text. Encryption enables an individual to avoid such filtering, allowing information to flow across borders. Moreover, individuals do not control — and are usually unaware of — how or if their communications cross borders. Encryption and anonymity may protect information of all individuals as it transits through servers located in third countries that filter content.

26. **Through any media:** Articles 19 of the Universal Declaration and the International Covenant on Civil and Political Rights were drafted with the foresight to accommodate future technological advances (A/HRC/17/27). The States parties to the Covenant chose to adopt the general phrase “through any other media” as opposed to an enumeration of then-existing media. Partly on this basis, international mechanisms have repeatedly acknowledged that the protections of freedom of expression apply to activities on the Internet. Regional courts have likewise recognized that protections apply online.¹³ The European Court of Human Rights, in discussing the similar protection of expression in the European Convention for the Protection of Human Rights and Fundamental Freedoms, has indicated that the forms and means through which information is transmitted and received are themselves protected, since any restriction imposed on the means necessarily interferes with the right to receive and impart information.¹⁴ In this sense, encryption and anonymity technologies are specific media through which individuals exercise their freedom of expression.

D. Roles of corporations

27. Corporations in a variety of sectors play roles in advancing or interfering with privacy, opinion and expression, including encryption and anonymity. Much online communication (and virtually all of it in some countries) is carried on networks owned and operated by private corporations, while other corporations own and manage websites with substantial user-generated content. Others are active players in the surveillance and spyware markets, providing hardware and software to Governments to compromise the security of individuals online. Others develop and provide services for secure and private online storage. Telecommunications entities, Internet service providers, search engines,

¹² The European Court of Human Rights has recognized this point. See *Ahmet Yildirim v. Turkey* (2012), *Cox v. Turkey* (2010), *Case of Groppera Radio AG and Others v. Switzerland* (1990).

¹³ European Commission of Human Rights, *Ney and Sunde Kolmisoppi v. Sweden* (2013); European Court of Human Rights, *Perrin v. United Kingdom* (2005); African Court on Human and Peoples' Rights, *Zimbabwe Lawyers for Human Rights and Institute for Human Rights and Development (on behalf of Melderu) v. Zimbabwe* (2009); *Case of Herrera Ulloa v. Costa Rica*, *Herrera Ulloa v. Costa Rica*, Preliminary Objections, Merits, Reparations and Costs, Serie: C No. 107, IHRL 1490 (IACHR 2004).

¹⁴ See *Autronic AG v. Switzerland* (1990), *De Haes and Gijssels v. Belgium* (1997), para. 48, *News Verlags GmbH and Co KG v. Austria* (2000).

cloud services and many other corporate actors, often described as intermediaries, promote, regulate or compromise privacy and expression online. Intermediaries may store massive volumes of user data, to which Governments often demand access. Encryption and anonymity may be promoted or compromised by each of these corporate actors.

28. A full exploration of the role of corporations to protect their users' security online is beyond the scope of the present report, which is focused on State obligations. However, it remains important to emphasize that "the responsibility to respect human rights applies throughout a company's global operations regardless of where its users are located, and exists independently of whether the State meets its own human rights obligations" (see A/HRC/27/37, para. 43). At a minimum, corporations should apply principles such as those laid out in the http://www.ohchr.org/documents/publications/guidingprinciplesbusinesshr_en.pdf Guiding Principles

http://www.ohchr.org/documents/publications/guidingprinciplesbusinesshr_en.pdf on Business and Human Rights, the Global Network Initiative's Principles on Freedom of Expression and Privacy, the European Commission's ICT Sector Guide on Implementing the UN Guiding Principles on Business and Human Rights and the Telecommunications Industry Dialogue Guiding Principles, which encourage corporations to commit to protect human rights, undertake due diligence to ensure the positive human rights impact of their work and remediate adverse impacts of their work on human rights. In the future, the Special Rapporteur will focus on the roles corporations should play in preserving individual security to exercise freedom of opinion and expression.

IV. Evaluating restrictions on encryption and anonymity

A. Legal framework

29. The permissible limitations on the right to privacy should be read strictly, particularly in an age of pervasive online surveillance — whether passive or active, mass or targeted — regardless of whether the applicable standards are "unlawful and arbitrary" under article 17 of the International Covenant on Civil and Political Rights, "arbitrary" under article 12 of the Universal Declaration, "arbitrary or abusive" under article 11 of the American Convention on Human Rights, or "necessary in a democratic society" under article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (see A/HRC/13/37, paras. 14–19). Privacy interferences that limit the exercise of the freedoms of opinion and expression, such as those described in this report, must not in any event interfere with the right to hold opinions, and those that limit the freedom of expression must be provided by law and necessary and proportionate to achieve one of a handful of legitimate objectives.

30. No restrictions may be imposed on the right to hold opinions without interference; restrictions under article 19 (3) of the Covenant only apply to expression under article 19 (2). In environments where one's opinions, however held online, result in surveillance or harassment, encryption and anonymity may provide necessary privacy. Restrictions on such security tools may interfere with the ability of individuals to hold opinions.

31. Restrictions on encryption and anonymity, as enablers of the right to freedom of expression, must meet the well-known three-part test: any limitation on expression must be provided for by law; may only be imposed for legitimate grounds (as set out in article 19 (3) of the Covenant); and must conform to the strict tests of necessity and proportionality.

32. First, for a restriction on encryption or anonymity to be "provided for by law", it must be precise, public and transparent, and avoid providing State authorities with

unbounded discretion to apply the limitation (see Human Rights Committee, general comment No. 34 (2011)). Proposals to impose restrictions on encryption or anonymity should be subject to public comment and only be adopted, if at all, according to regular legislative process. Strong procedural and judicial safeguards should also be applied to guarantee the due process rights of any individual whose use of encryption or anonymity is subject to restriction. In particular, a court, tribunal or other independent adjudicatory body must supervise the application of the restriction.¹⁵

33. Second, limitations may only be justified to protect specified interests: rights or reputations of others; national security; public order; public health or morals. Even where a State prohibits by law “advocacy of national, racial or religious hatred that constitutes incitement to discrimination, hostility or violence, as provided by Article 20 of the Covenant, any restrictions on expression must be consistent with Article 19(3) (A/67/357). No other grounds may justify restrictions on the freedom of expression. Moreover, because legitimate objectives are often cited as a pretext for illegitimate purposes, the restrictions themselves must be applied narrowly.¹⁶

34. Third, the State must show that any restriction on encryption or anonymity is “necessary” to achieve the legitimate objective.¹⁷ The European Court of Human Rights has concluded appropriately that the word “necessary” in article 10 of the European Convention for the Protection of Human Rights and Fundamental Freedoms means that the restriction must be something more than “useful,” “reasonable” or “desirable”.¹⁸ Once the legitimate objective has been achieved, the restriction may no longer be applied. Given the fundamental rights at issue, limitations should be subject to independent and impartial judicial authority, in particular to preserve the due process rights of individuals.

35. Necessity also implies an assessment of the proportionality of the measures limiting the use of and access to security online.¹⁹ A proportionality assessment should ensure that the restriction is “the least intrusive instrument amongst those which might achieve the desired result”.²⁰ The limitation must target a specific objective and not unduly intrude upon other rights of targeted persons, and the interference with third parties’ rights must be limited and justified in the light of the interest supported by the intrusion. The restriction

¹⁵ See International Covenant on Civil and Political Rights, article 2 (3)(b), CCPR/C/79/Add.110, para. 22; the Johannesburg Principles on National Security, Freedom of Expression and Access to Information.

¹⁶ See Human Rights Committee, general comment No. 34 on freedom of opinion and expression, para. 30, and http://tbinternet.ohchr.org/_layouts/treatybodyexternal/download.aspx?symbolno=ccpr%252f%2521%252frev.1%252fadd.13&lang=en&general http://tbinternet.ohchr.org/_layouts/treatybodyexternal/download.aspx?symbolno=ccpr%252f%2521%252frev.1%252fadd.13&lang=en&comment No. 31.

¹⁷ See Human Rights Committee, general comment No. 34, para. 2, and communication No. 2156/2012, Views adopted on 10 October 2014.

¹⁸ See *Case of The Sunday Times v. United Kingdom*, judgement of 26 April 1979, para. 59.

¹⁹ See African Court Human and Peoples’ Rights, *Lohé Issa Konaté v. Burkina Faso*, application No. 004/2013, paras. 148 and 149 (2014); European Court of Human Rights, *Case of The Sunday Times*, para. 62.

²⁰ See Human Rights Committee, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/download.aspx?symbolno=ccpr%252f%2521%252frev.1%252fadd.9&lang=en&general http://tbinternet.ohchr.org/_layouts/treatybodyexternal/download.aspx?symbolno=ccpr%252f%2521%252frev.1%252fadd.9&lang=en&comment No. 27 (1999) on freedom of movement, para. 14.

must also be “proportionate to the interest to be protected”.²¹ A high risk of damage to a critical, legitimate State interest may justify limited intrusions on the freedom of expression. Conversely, where a restriction has a broad impact on individuals who pose no threat to a legitimate government interest, the State’s burden to justify the restriction will be very high.²² Moreover, a proportionality analysis must take into account the strong possibility that encroachments on encryption and anonymity will be exploited by the same criminal and terrorist networks that the limitations aim to deter. In any case, “a detailed and evidence-based public justification” is critical to enable transparent public debate over restrictions that implicate and possibly undermine freedom of expression (see A/69/397, para. 12).

B. State practice: examples and concerns

36. The trend lines regarding security and privacy online are deeply worrying. States often fail to provide public justification to support restrictions. Encrypted and anonymous communications may frustrate law enforcement and counter-terrorism officials, and they complicate surveillance, but State authorities have not generally identified situations — even in general terms, given the potential need for confidentiality — where a restriction has been necessary to achieve a legitimate goal. States downplay the value of traditional non-digital tools in law enforcement and counter-terrorism efforts, including transnational cooperation.²³ As a consequence, the public lacks an opportunity to measure whether restrictions on their online security would be justified by any real gains in national security and crime prevention. Efforts to restrict encryption and anonymity also tend to be quick reactions to terrorism, even when the attackers themselves are not alleged to have used encryption or anonymity to plan or carry out an attack. Moreover, even where the restriction is arguably in pursuit of a legitimate interest, many laws and policies regularly do not meet the standards of necessity and proportionality and have broad, deleterious effects on the ability of all individuals to exercise freely their rights to privacy and freedom of opinion and expression.

37. It also bears noting that the United Nations itself has not provided strong communication security tools to its staff or to those who would visit United Nations websites, making it difficult for those under threat to securely reach the United Nations, human rights mechanisms online.²⁴

I. Encryption

38. Some Governments seek to protect or promote encryption to ensure the privacy of communications. For instance,²⁵ the Marco Civil da Internet Law of Brazil, adopted in 2014, guarantees the inviolability and secrecy of user communications online, permitting exceptions only by court order. The E-Commerce Act and Telecommunication Act of Austria do not restrict encryption, and the Government has undertaken public awareness

²¹ See *ibid.*, para. 14.

²² See Inter-American Commission on Human Rights, OEA/Ser.L/V/II.149, para. 134.

²³ But see Centre for International Governance Innovation and Chatham House, *Toward a Social Compact for Digital Privacy and Security: Statement by the Global Commission on Internet Governance* (2015), https://ourinternet-files.s3.amazonaws.com/publications/gcig_social_compact.pdf

²⁴ For instance, staff of the Office of the United Nations High Commissioner for Human Rights (OHCHR) in Geneva do not have access to end-to-end e-mail encryption, and the OHCHR website is not encrypted.

²⁵ Many examples in this paragraph are taken from the relevant government submissions.

campaigns to educate the public about digital security. Greek law and regulations promote the effective use of both encryption and anonymity tools. Germany, Ireland and Norway permit and promote the use of encryption technologies and oppose any efforts to weaken encryption protocols. Similarly, Swedish and Slovak laws do not restrict the use of encryption online. The United States of America encourages the use of encryption, and the United States Congress should further consider a secure data act introduced in the Congress that would prohibit the Government from requiring companies to weaken product security or insert back-door access measures. Several Governments fund efforts to share or train in the use of encryption and anonymity technologies to help individuals evade censorship and protect their security online, including Canada, the Netherlands, Sweden, the United Kingdom of Great Britain and Northern Ireland and the United States. In addition, export regulations should facilitate the transfer of encryption technologies wherever possible. Although the present report does not provide an overall legal assessment of all national approaches to encryption, these noted elements — non-restriction or comprehensive protection, the requirement of court orders for any specific limitation, and public education — deserve wider application as means to protect and promote the rights to freedom of opinion and expression.

39. Nonetheless, the regulation of encryption often fails to meet freedom of expression standards in two leading respects. First, restrictions have generally not been shown to be necessary to meet a particular legitimate interest. This is especially the case given the breadth and depth of other tools, such as traditional policing and intelligence and transnational cooperation, that may already provide substantial information for specific law enforcement or other legitimate purposes. Second, they disproportionately impact the rights to freedom of opinion and expression enjoyed by targeted persons or the general population.

Bans on encryption for individual use

40. Outright prohibitions on the individual use of encryption technology disproportionately restrict the freedom of expression, because they deprive all online users in a particular jurisdiction of the right to carve out private space for opinion and expression, without any particular claim of the use of encryption for unlawful ends.

41. State regulation of encryption may be tantamount to a ban, such as rules (a) requiring licences for encryption use; (b) setting weak technical standards for encryption; and (c) controlling the import and export of encryption tools. By limiting encryption tools to government-approved standards and controlling the import or export of encryption technologies, States ensure encryption software maintains weaknesses that allow Governments to access the content of communications. For example, while the law may be in flux, India has provided that service providers may not deploy “bulk encryption” on their networks, while the law has also restricted individuals from using encryption greater than an easily breakable 40-bit key length without prior permission and required anyone using stronger encryption to provide the Government with a copy of the encryption keys.²⁶ Reports indicate that encryption products in China may be required to adhere to government-approved encryption algorithms that have not been peer-reviewed for security.²⁷ The Pakistan Telecommunication Authority requires prior approval for the use of

²⁶ Government of India, Ministry of Communications and IT, Licence Agreement for Provision of Internet Services, (2007). Available from http://dot.gov.in/sites/default/files/internet-licence-dated%2016-10-2007_0.pdf. See especially sect. 2.2 (vii).

²⁷ See, e.g., Counter-terrorism Law, art. 15 (initial draft of 8 November 2014). Available from <http://chinalawtranslate.com/en/ctldraft/>.

VPNs and encryption.²⁸ Cuba requires regulatory authorization for those using encryption.²⁹ In Ethiopia, the Government has the power to set the technical standards of encryption and recently enacted regulation that criminalizes the manufacture, assembly or import of any telecommunications equipment without a permit.³⁰ Such regulations impermissibly interfere with the individual use of encryption in communications.

Intentional weakening of encryption

42. Some States have implemented or proposed implementing so-called back-door access in commercially available products, forcing developers to install weaknesses that allow government authorities access to encrypted communications. Some Governments have developed or purchased tools to allow such access for domestic surveillance purposes.³¹ Senior officials in the United Kingdom and the United States appear to advocate requiring back-door access.³² States supporting such measures often claim that a legal framework for back-door access is necessary to intercept the content of encrypted communications. Governments proposing back-door access, however, have not demonstrated that criminal or terrorist use of encryption serves as an insuperable barrier to law enforcement objectives. Moreover, based on existing technology, intentional flaws invariably undermine the security of all users online, since a backdoor, even if intended solely for government access, can be accessed by unauthorized entities, including other States or non-State actors. Given its widespread and indiscriminate impact, back-door access would affect, disproportionately, all online users.

43. The debate on this issue highlights a critical point: requiring encryption back-door access, even if for legitimate purposes, threatens the privacy necessary to the unencumbered exercise of the right to freedom of expression. Back-door access has

²⁸ See www.ispak.pk/Downloads/PTA_VPN_Policy.pdf

²⁹ Submission of Cuba.

³⁰ See Ethiopia Telecom Fraud Offence Proclamation 761/2012, sects. 3–10.

³¹ See Morgan Maquis-Boire and others, *For Your Eyes Only* (2013, Citizen Lab).

³² See the speech given by Prime Minister David Cameron <https://www.youtube.com/watch?v=juiibdvtzy8> <https://www.youtube.com/watch?v=juiibdvtzy8> <https://www.youtube.com/watch?v=juiibdvtzy8> <https://www.youtube.com/watch?v=juiibdvtzy8> <https://www.youtube.com/watch?v=juiibdvtzy8> on 12 January 2015 <https://www.youtube.com/watch?v=juiibdvtzy8> <https://www.youtube.com/watch?v=juiibdvtzy8> <https://www.youtube.com/watch?v=juiibdvtzy8> at the <https://www.youtube.com/watch?v=juiibdvtzy8> Conservative Party <https://www.youtube.com/watch?v=juiibdvtzy8> pledges conference for the 2015 general election and the speech given by James Comey, Director of the Federal Bureau of Investigation, on 16 October 2014, entitled “Going <http://www.fbi.gov/news/speeches/going-dark-are-technology-privacy-and-public-safety-on-a-collision-course> dark <http://www.fbi.gov/news/speeches/going-dark-are-technology-privacy-and-public-safety-on-a-collision-course> are <http://www.fbi.gov/news/speeches/going-dark-are-technology-privacy-and-public-safety-on-a-collision-course> technology <http://www.fbi.gov/news/speeches/going-dark-are-technology-privacy-and-public-safety-on-a-collision-course> and <http://www.fbi.gov/news/speeches/going-dark-are-technology-privacy-and-public-safety-on-a-collision-course> public <http://www.fbi.gov/news/speeches/going-dark-are-technology-privacy-and-public-safety-on-a-collision-course> safety on a <http://www.fbi.gov/news/speeches/going-dark-are-technology-privacy-and-public-safety-on-a-collision-course> collision <http://www.fbi.gov/news/speeches/going-dark-are-technology-privacy-and-public-safety-on-a-collision-course>?” at the Brookings Institution, Washington, D.C.

practical limitations; the exploitation of intentional weaknesses could render encrypted content susceptible to attack, even if access is provided with the sole intention of allowing government or judicial control. Governments certainly face a dilemma when their obligation to protect freedom of expression is in conflict with their obligations to prevent violations of the right to life or bodily integrity, which are put at risk by terrorism and other criminal behaviour. But other recourses are available to States to request the disclosure of encrypted information, such as through judicial warrants. In such situations, States must demonstrate that general limitations on the security provided by encryption would be necessary and proportionate. States must show, publicly and transparently, that other less intrusive means are unavailable or have failed and that only broadly intrusive measures, such as backdoors, would achieve the legitimate aim. Regardless, measures that impose generally applicable restrictions on massive numbers of persons, without a case-by-case assessment, would almost certainly fail to satisfy proportionality.

Key escrows

44. A key escrow system permits individual access to encryption but requires users to store their private keys with the Government or a "trusted third party". Key escrows, however, have substantial vulnerabilities. For instance, the key escrow system depends on the integrity of the person, department or system charged with safeguarding the private keys, and the key database itself could be vulnerable to attack, undermining any user's communication security and privacy. Key escrow systems, rejected (along with back-door access) after significant debate in the United States in the so-called Crypto Wars of the 1990s, are currently in place in several countries and have been proposed in others. In 2011, Turkey passed regulations requiring encryption suppliers to provide copies of encryption keys to government regulators before offering their encryption tools to users.³³ The vulnerabilities inherent in key escrows render them a serious threat to the security to exercise the freedom of expression.

Mandatory key disclosure versus targeted decryption orders

45. In a situation where law enforcement or national security arguments may justify requests for access to communications, authorities may see two options: order either decryption of particular communications or, because of a lack of confidence that a targeted party would comply with a decryption order, disclosure of the key necessary for decryption. Targeted decryption orders may be seen as more limited and less likely to raise proportionality concerns than key disclosure, focusing on specific communications rather than an individual's entire set of communications encrypted by a particular key. Key disclosure, by contrast, could expose private data well beyond what is required by the exigencies of a situation.³⁴ Moreover, key disclosure or decryption orders often force corporations to cooperate with Governments, creating serious challenges that implicate individual users online. Key disclosure exists by law in a number of European countries.³⁵ In both cases, however, such orders should be based on publicly accessible law, clearly limited in scope focused on a specific target, implemented under independent and impartial

³³ Law No. 5651 on Regulating Broadcasting in the Internet and Fighting against Crimes Committed through Internet Broadcasting.

³⁴ The European Commission Counter-Terrorism Coordinator has urged consideration of mandatory key disclosure. See Council of the European Union, General Secretariat, meeting document D1035/15 (2015).

³⁵ See, e.g., United Kingdom, Regulation of Investigatory Powers Act http://www.legislation.gov.uk/ukpga/2000/23/pdfs/ukpga_20000023_en.pdf (mandatory key disclosure); France, Law No. 2001-1062 (disclosure of encryption keys on authorization by a judge); Spain, Law on Telecommunications 25/2007 (key disclosure).

judicial authority, in particular to preserve the due process rights of targets, and only adopted when necessary and when less intrusive means of investigation are not available. Such measures may only be justified if used in targeting a specific user or users, subject to judicial oversight.

Legal presumptions

46. Some States may identify the mere use of encryption technologies as illicit behaviour. For instance, charges against the Zone 9 blogger collective in Ethiopia included suggestions that the mere training in communication security was evidence of criminal behaviour.³⁶ Such presumptions fail to meet the standards for permissible restrictions. Similarly, States undermine the rights to privacy and freedom of expression when they penalize those who produce and distribute tools to facilitate online access for activists.

2. Anonymity

47. Anonymity has been recognized for the important role it plays in safeguarding and advancing privacy, free expression, political accountability, public participation and debate.³⁷ The Universal Declaration and the International Covenant on Civil and Political Rights do not address anonymity. During negotiation of the Covenant, it was proposed to include in article 19 (1) the phrase, "anonymity is not permitted". However, this was rejected "on the grounds, among others, that anonymity might at times be necessary to protect the author" and "that such a clause might prevent the use of pen names".³⁸ The Special Rapporteur on Freedom of Expression of the Inter-American Commission on Human Rights found that "the right to freedom of thought and expression and the right to private life protect anonymous speech from government restrictions".³⁹ Several States enjoy long traditions of celebrating anonymity in their political cultures, but very few provide general protection in law for anonymous expression. Some States exert significant pressure against anonymity, offline and online. Yet because anonymity facilitates opinion and expression in significant ways online, States should protect it and generally not restrict the technologies that provide it. Several States' judiciaries have protected anonymity, at least in limited instances. For instance, the Supreme Court of Canada recently struck down the warrantless acquisition of anonymous user identity online.⁴⁰ The Constitutional Court of the Republic of Korea struck down anti-anonymity laws as unconstitutional.⁴¹ The Supreme Court of the United States has consistently protected the right to anonymous expression.⁴² The European Court of Human Rights has recognized anonymity as important to the freedom of expression but permits limitations in cases where necessary to achieve legitimate objectives.

³⁶ See <http://trialtrackerblog.org/2014/07/19/contextual-translation-of-the-charges-of-the-zone9-bloggers/>.

³⁷ See, e.g., Inter-American Commission on Human Rights, https://www.oas.org/en/iachr/expression/docs/reports/2014_04_22_ia_2013_eng_finalweb.pdf (OEA/Ser.L/V/II.149, para. 134; United States, *McIntyre v. Ohio Elections Commission* (1995), Lord Neuberger, speech to RB Conference on the Internet, entitled, "What's a name? Privacy and Anonymous Speech on the Internet" (2014)).

³⁸ Marc J. Bossuyt, *Guide to the "Travaux Préparatoires" of the International Covenant on Civil and Political Rights* (1987), pp. 379-80.

³⁹ See Organization of American States, press release 17/15.

⁴⁰ *R. v. Spencer* (2014).

⁴¹ Decision 2010 Hun-Ma 47, 252 (consolidated) announced 28 August 2012.

⁴² *McIntyre v. Ohio Elections Commission* (1995), pp. 342 and 343.

48. Many States recognize the lawfulness of maintaining the anonymity of journalists' sources. The Mexican Supreme Court and Mexican Code of Criminal Procedures recognize the right of journalists to maintain the anonymity of their sources; yet pressures on journalists are in fact severe.⁴³ The Constitutions of Argentina, Brazil, Ecuador and Paraguay explicitly protect sources; Chile, El Salvador, Panama, Peru, Uruguay and Venezuela (Bolivarian Republic of) protect sources in law.⁴⁴ The Mozambique Constitution protects sources, while Angola purports to do so by statute.⁴⁵ Australia, Canada, Japan and New Zealand have established case-specific judicial balancing tests to analyse source protection, although pressure on journalists may undermine such protections over time.⁴⁶ States often breach source anonymity in practice, even where it is provided for in law.

Prohibition of anonymity

49. Prohibition of anonymity online interferes with the right to freedom of expression. Many States ban it regardless of any specific government interest. The Constitution of Brazil (art. 5) prohibits anonymous speech.⁴⁷ Constitution of the Bolivarian Republic of Venezuela (art. 57) similarly prohibits anonymity. In 2013, Viet Nam outlawed the use of pseudonyms, which forced individuals with personal blogs to publicly list their real name and address.⁴⁷ In 2012, the Islamic Republic of Iran required the registration of all IP addresses in use inside the country and cybercafé users to register their real names before using a computer.⁴⁸ Ecuadoran law requires commenters on websites and mobile phone owners to register under a real name.⁴⁹

50. Certain States have passed laws that require real-name registration for online activity, a kind of ban on anonymity. In the Russian Federation, bloggers with 3,000 or more daily readers must register with the media regulator and identify themselves publicly, and cybercafé users reportedly must provide identification to connect to public wireless facilities.⁵⁰ China reportedly announced regulations requiring Internet users to register real

⁴³ See new Federal Code of Criminal Procedures, art. 244.

⁴⁴ See Argentina, Constitution, art. 43; Brazil, Constitution, title II, chap. I, art. 5, XIV; Ecuador, Constitution, art. 20; Paraguay, Constitution, art. 29 (1). See also Chile, Law 19,733; El Salvador, Criminal Procedure Code; Panama, Law 67, art. 21; Peru, Criminal Procedure Code; Uruguay, Law 16 099; Bolivarian Republic of Venezuela, Law for Journalism 4.819, art. 8.

⁴⁵ See Mozambique, Constitution, art. 48(3); Angola, Press Law 7/06, art. 20(1).

⁴⁶ Australia Evidence Amendment (Journalists' Privilege) Act 2007; Canada, Court of Queen's Bench of Alberta, *Wasylshen v. Canadian Broadcasting Corporation* (2005); Japan, Case 2006 (Kyo) No. 19 (2006); New Zealand Evidence Act, sect. 68 (2006).

⁴⁷ Human Rights Watch, "Vietnam: <http://www.hrw.org/news/2011/02/23/vietnam-new-decree-punishes-pressnew> <http://www.hrw.org/news/2011/02/23/vietnam-new-decree-punishes-pressdece> <http://www.hrw.org/news/2011/02/23/vietnam-new-decree-punishes-presspunishes> <http://www.hrw.org/news/2011/02/23/vietnam-new-decree-punishes-presspress>", 23 February, 2011; Freedom House, "Vietnam: freedom of the press", 2012; Article 19, Comment <http://www.article19.org/data/files/medialibrary/1830/11-06-20-comm-vietnam.pdf> on <http://www.article19.org/data/files/medialibrary/1830/11-06-20-comm-vietnam.pdf> Decree No. 02 of 2011 on Administrative Responsibility for Press and Publication Activities of the Prime Minister of the Socialist Republic of Vietnam (June 2011).

⁴⁸ Islamic Republic of Iran, Bill 106, Communication Regulation Authority.

⁴⁹ See

http://www.derechoambiental.org/derecho/legislacion/ley_organica_comunicacion_ecuador_2013.html Ecuador, Organic Law on Communications (2013).

⁵⁰ Bill No. 428884-6

<http://asozd2.duma.gov.ru/main.nsf/%2528spravkanew%2529?openagent&rn=428884-6&02>

<http://asozd2.duma.gov.ru/main.nsf/%2528spravkanew%2529?openagent&rn=428884->

names for certain websites and avoid spreading content that challenges national interests.⁵¹ South Africa also requires real name registration for online and mobile telephone users.⁵²

51. Likewise, Governments often require SIM card registration; for instance, nearly 50 countries in Africa require or are in the process of requiring the registration of personally identifiable data when activating a SIM card.⁵³ Colombia has had a mandatory mobile registration policy since 2011, and Peru has associated all SIM cards with a national identification number since 2010.⁵⁴ Other countries are considering such policies. Such policies directly undermine anonymity, particularly for those who access the Internet only through mobile technology. Compulsory SIM card registration may provide Governments with the capacity to monitor individuals and journalists well beyond any legitimate government interest.

52. States have also attempted to combat anonymity tools, such as Tor, proxies and VPNs, by denying access to them. China has long blocked access to Tor,⁵⁵ and Russian government officials reportedly offered more than \$100,000 for techniques to identify

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6&02<http://asozd2.duma.gov.ru/main.nsf/%2528spravkanew%2529?openagent&rn=428884-6&02> networks; Reuters, "Russia Demands Internet Users Show ID to Access Public Wifi," 8 August 2014.

⁵¹ China Copyright and Media, Internet User Account Name Management Regulations, article 5 (2015).

⁵² South Africa, Regulation of Interception of Communications and Provision of Communication-Related Information Act 70 of 2003, see also Electronic Communications and Transactions Act of 2002 (requiring real name registration for service providers).

⁵³ Kevin P. Donovan and Aaron K. Martin, "The Rise of African SIM Registration", 3 February 2014.

⁵⁴ See Colombia, Decree 1630 of 2011; Peru 21, *Los celulares de prepago en la mira*, 27 May 2010.

⁵⁵ MIT Technology Review, *How China Blocks the Tor Anonymity Network*, 4 April 2012.

anonymous users of Tor.⁵⁶ In addition, Ethiopia,⁵⁷ Iran (Islamic Republic of)⁵⁸ and Kazakhstan⁵⁹ have reportedly sought to block Tor traffic. Because such tools may be the only mechanisms for individuals to exercise freedom of opinion and expression securely, access to them should be protected and promoted.

Restrictions during public unrest

53. Anonymous speech has been necessary for activists and protestors, but States have regularly attempted to ban or intercept anonymous communications in times of protest. Such attempts to interfere with the freedom of expression unlawfully pursue an illegitimate objective of undermining the right to peaceful protest under the Universal Declaration and the International Covenant on Civil and Political Rights.

Intermediary liability

54. Some States and regional courts have moved towards imposing responsibilities on Internet service providers and media platforms to regulate online comments by anonymous users. Ecuador, for instance, in its Organic Communications Law, requires intermediaries to generate mechanisms to record personal data to allow the identification of those posting comments. In *Delfi v. Estonia* (application No. 64569/09), the European Court of Human Rights upheld an Estonian law that imposes liability on a media platform for anonymous defamatory statements posted on its site. Such intermediary liability is likely to result either in real-name registration policies, thereby undermining anonymity, or the elimination of posting altogether by those websites that cannot afford to implement screening procedures, thus harming smaller, independent media. The recently adopted Manila Principles on Intermediary Liability, drafted by a coalition of civil society organizations, provide a sound set of guidelines for States and international and regional mechanisms to protect expression online.

Data retention

55. Broad mandatory data retention policies limit an individual's ability to remain anonymous. A State's ability to require Internet service and telecommunications providers to collect and store records documenting the online activities of all users has inevitably resulted in the State having everyone's digital footprint. A State's ability to collect and retain personal records expands its capacity to conduct surveillance and increases the potential for theft and disclosure of individual information.

V. Conclusions and recommendations

56. **Encryption and anonymity, and the security concepts behind them, provide the privacy and security necessary for the exercise of the right to freedom of opinion and expression in the digital age. Such security may be essential for the exercise of other**

⁵⁶ The original offer is available <http://zakupki.gov.ru/cpz/order/notice/zkk44/view/common-info.html?regnumber=0373100088714000008> from <http://zakupki.gov.ru/cpz/order/notice/zkk44/view/common-info.html?regNumber=0373100088714000008>.

⁵⁷ Runa Sandvik, Ethiopia Introduces Deep Packet Inspection, The Tor Blog (31 May 2012); see also Article 19, 12 January 2015.

⁵⁸ "Phobos", "Iran partially blocks encrypted network traffic", The Tor Blog (10 February 2012).

⁵⁹ "Phobos", "Kazakhstan upgrades censorship to deep packet inspection", The Tor Blog (16 February 2012).

rights, including economic rights, privacy, due process, freedom of peaceful assembly and association, and the right to life and bodily integrity. Because of their importance to the rights to freedom of opinion and expression, restrictions on encryption and anonymity must be strictly limited according to principles of legality, necessity, proportionality and legitimacy in objective. The Special Rapporteur therefore recommends the following.

A. States

57. States should revise or establish, as appropriate, national laws and regulations to promote and protect the rights to privacy and freedom of opinion and expression. With respect to encryption and anonymity, States should adopt policies of non-restriction or comprehensive protection, only adopt restrictions on a case-specific basis and that meet the requirements of legality, necessity, proportionality and legitimacy in objective, require court orders for any specific limitation, and promote security and privacy online through public education.

58. Discussions of encryption and anonymity have all too often focused only on their potential use for criminal purposes in times of terrorism. But emergency situations do not relieve States of the obligation to ensure respect for international human rights law. Legislative proposals for the revision or adoption of restrictions on individual security online should be subject to public debate and adopted according to regular, public, informed and transparent legislative process. States must promote effective participation of a wide variety of civil society actors and minority groups in such debate and processes and avoid adopting such legislation under accelerated legislative procedures. General debate should highlight the protection that encryption and anonymity provide, especially to the groups most at risk of unlawful interferences. Any such debate must also take into account that restrictions are subject to strict tests: if they interfere with the right to hold opinions, restrictions must not be adopted. Restrictions on privacy that limit freedom of expression — for purposes of the present report, restrictions on encryption and anonymity — must be provided by law and be necessary and proportionate to achieve one of a small number of legitimate objectives.

59. States should promote strong encryption and anonymity. National laws should recognize that individuals are free to protect the privacy of their digital communications by using encryption technology and tools that allow anonymity online. Legislation and regulations protecting human rights defenders and journalists should also include provisions enabling access and providing support to use the technologies to secure their communications.

60. States should not restrict encryption and anonymity, which facilitate and often enable the rights to freedom of opinion and expression. Blanket prohibitions fail to be necessary and proportionate. States should avoid all measures that weaken the security that individuals may enjoy online, such as backdoors, weak encryption standards and key escrows. In addition, States should refrain from making the identification of users a condition for access to digital communications and online services and requiring SIM card registration for mobile users. Corporate actors should likewise consider their own policies that restrict encryption and anonymity (including through the use of pseudonyms). Court-ordered decryption, subject to domestic and international law, may only be permissible when it results from transparent and publicly accessible laws applied solely on a targeted, case-by-case basis to individuals (i.e., not to a mass of people) and subject to judicial warrant and the protection of due process rights of individuals.

B. International organizations, private sector and civil society

61. States, international organizations, corporations and civil society groups should promote online security. Given the relevance of new communication technologies in the promotion of human rights and development, all those involved should systematically promote access to encryption and anonymity without discrimination. The Special Rapporteur urgently calls upon entities of the United Nations system, especially those involved in human rights and humanitarian protection, to support the use of communication security tools in order to ensure that those who interact with them may do so securely. United Nations entities must revise their communication practices and tools and invest resources in enhancing security and confidentiality for the multiple stakeholders interacting with the Organization through digital communications. Particular attention must be paid by human rights protection mechanisms when requesting and managing information received from civil society and witnesses and victims of human rights violations.

62. While the present report does not draw conclusions about corporate responsibilities for communication security, it is nonetheless clear that, given the threats to freedom of expression online, corporate actors should review the adequacy of their practices with regard to human right norms. At a minimum, companies should adhere to principles such as those laid out in the http://www.ohchr.org/documents/publications/guidingprinciplesbusinesshr_en.pdf Guiding Principles

http://www.ohchr.org/documents/publications/guidingprinciplesbusinesshr_en.pdf on

Business and Human Rights, the Global Network Initiative's Principles on Freedom of Expression and Privacy, the European Commission's ICT Sector Guide on Implementing the UN Guiding Principles on Business and Human Rights, and the Telecommunications Industry Dialogue Guiding Principles. Companies, like States, should refrain from blocking or limiting the transmission of encrypted communications and permit anonymous communication. Attention should be given to efforts to expand the availability of encrypted data-centre links, support secure technologies for websites and develop widespread default end-to-end encryption. Corporate actors that supply technology to undermine encryption and anonymity should be especially transparent as to their products and customers.

63. The use of encryption and anonymity tools and better digital literacy should be encouraged. The Special Rapporteur, recognizing that the value of encryption and anonymity tools depends on their widespread adoption, encourages States, civil society organizations and corporations to engage in a campaign to bring encryption by design and default to users around the world and, where necessary, to ensure that users at risk be provided the tools to exercise their right to freedom of opinion and expression securely.

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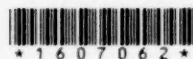
**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development****Report of the Special Rapporteur on the right of everyone to
the enjoyment of the highest attainable standard of physical
and mental health, Dainius Pūras***Summary*

In the present report, submitted pursuant to Council resolution 24/6, the Special Rapporteur provides a brief account of his activities since he took office in August 2014.

The main focus of the report is on the work of the mandate of the Special Rapporteur on the right to health, focusing on the right to health framework, and the development of the contours and content of the right to health. He then reflects on how he sees the way forward, based on the current context, challenges and opportunities for the full realisation of the right to health.

The Special Rapporteur provides his conclusions and observations.

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I. Introduction

1. The present report is the first submitted to the Council by the newly appointed Special Rapporteur, Dainius Pūras, and is the twenty-fourth thematic report submitted by the mandate holder on the enjoyment of the right to health since the establishment of the mandate in 2003. The report is submitted pursuant to Council resolution 24/6.

2. The Special Rapporteur provides a brief account of his activities since his appointment, including communications, country visits and cooperation with the United Nations system and other key stakeholders.

3. The Special Rapporteur provides an overview of the work of the mandate since 2003, focusing on the right to health framework, and the development of the contours and content of the right to health. He then reflects on how he sees the way forward, based on the current context, challenges and opportunities for the full realization of the right to health. He lays out the main themes as priorities for the coming years. In the final chapter, the Special Rapporteur provides his conclusions and observations.

II. Activities during the reporting period

A. Communications transmitted to States

4. During the reporting period, between 1 March 2014 and 28 February 2015, the Special Rapporteurs sent 72 communications to 39 States. At the time of writing, 36 responses had been received, indicating a 52 per cent response rate.

B. Country visits

5. During the reporting period, the Special Rapporteur visited Malaysia from 19 November to 2 December 2014. He would like to thank the Government for extending this invitation and facilitating the visit. A separate report on this visit has been submitted as addenda 1 to the present report (A/HRC/29/33/Add.1). Comments by the Government thereon have been submitted (A/HRC/29/33/Add.2).

6. The Special Rapporteur would like to thank the Government of Algeria for having extended an invitation to conduct a country visit, and hopes this visit will take place in the coming months.

C. Cooperation with the United Nations system and intergovernmental organizations

7. The Special Rapporteur participated in sessions, meetings and events linked to the discharge of his mandate, including the induction course for new mandate holders (3–5 September 2014); the 21st Annual Meeting of Special Procedures of the Human Rights Council (29 September–3 October 2014); and the sixty-ninth session of the General Assembly (27–30 October 2014).

8. In addition, on 18 September 2014, the Special Rapporteur participated as panellist in the high-level launch of the technical guidance on the application of a human rights-based approach to reduce and eliminate preventable mortality and morbidity of children under 5 years of age, which took place in Geneva.

9. From 9 to 11 December 2014, the Special Rapporteur was invited to attend the Programme Coordinating Board meeting of the Joint United Nations Programme on HIV/AIDS, which took place in Geneva. In the context of that meeting, the Special Rapporteur participated in various meetings and events, including on harm reduction issues.

10. On 16 and 17 October 2014, the Special Rapporteur was invited to participate in the symposium on the rights of persons with psychosocial disabilities, which was organized by OHCHR Regional Office for Europe in Brussels.

11. From 18 to 20 February, the Special Rapporteur participated as panellist at the 2015 Social Forum, which took place in Geneva and focused on access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including best practices in this regard.

D. Cooperation with non-governmental organizations

12. On 3 October 2014, the Special Rapporteur participated in an event on "Autism and Human Rights throughout the Life Course", organized by the NGO Forum for Health and which took place in Geneva.

III. Overview of the work of the mandate (2003–2014)

13. The mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health was originally established by the Commission on Human Rights in April 2002 in resolution 2002/31, and renewed in 2005 in resolution 2005/24. Subsequent to the replacement of the Commission with the Human Rights Council in June 2006, the mandate was endorsed and extended by the Council through resolutions 6/29, 15/22 and 24/6.

14. The new Special Rapporteur was appointed in August 2014 and feels privileged to have been given the opportunity to assess the realization of the right to health in the coming years. He will make use of his voice and of all tools available to discharge his mandate and contribute to the full enjoyment of the right to health by all. In his first report to the Human Rights Council, the Special Rapporteur focuses on the work of the mandate, including challenges and opportunities, and on how he sees the way forward in the discharge of his functions.

15. During the first years of the existence of the mandate, the first Special Rapporteur, in collaboration with the Committee on Economic, Social and Cultural Rights, the World Health Organization (WHO), civil society and the academic sector, developed a framework for analysing the right to health with a view to making it easier to understand and apply to health-related policies, programmes and projects in practice.

16. The analytical framework that was developed consists of several key elements and has a general and inclusive application to all aspects of the right to health, including the underlying and social determinants of health and timely and appropriate medical care. The framework is intended to address the crucial question of what human rights in general, and what the right to health in particular, bring to policymaking process (see E/CN.4/2003/58, para. 9). That question remains valid today and will continue guiding the work of the Special Rapporteur.

17. The first mandate holder identified three primary objectives for the mandate: to promote — and encourage others to promote — the right to health as a fundamental human right; to clarify the contours and content of the right to health; and to identify good practices for the operationalization of the right to health at the community, national and

international levels (see E/CN.4/2003/58, para. 9). The then Special Rapporteur explored those three objectives by way of two interrelated themes: the right to health in relation to poverty, focusing on health-related Millennium Development Goals; and the right to health and the determinants of discrimination and stigma.

18. Throughout his tenure, the former Special Rapporteur Paul Hunt distinguished between judicially oriented and policy-oriented processes. Although the two approaches are closely related and mutually reinforcing, the former aims to promote and protect the right to health via the drawing up of rules and principles derived from case law, building up general guidance from the lessons learned via the resolution of particular disputes. Judicial and quasi-judicial forms of accountability exemplify this approach. The former Rapporteur also emphasized that the policy approach is not a soft option, on the contrary, it places a legal obligation on policymakers to ensure that a health system includes comprehensive health plans encompassing the public and private sectors, outreach programmes for the disadvantaged and numerous other features demanded by the right to health. The policy approach is not without accountability: it requires that policymakers are subject to judicial and non-judicial forms of review.

19. The work of the mandate has addressed the challenges and opportunities related to progressive realization of the right to health and those obligations that have immediate effect. With regard to resource constraints and progressive realization, international human rights law recognizes that the realization of the right to health is subject to progressive realization based on resource availability. That is why a higher standard is required of a developed State today than is required of a developing State. However, all States are obliged to realize progressively the right to the highest attainable standard of health. In order to measure progress, indicators and benchmarks need to be identified, and the work of the first mandate holder in that regard continues to be very useful (see A/58/427 and E/CN.4/2006/58).

20. Previous mandate holders have given details of the challenges and opportunities that arise from the right to available, accessible, acceptable and good-quality health-care services. In that regard, health-care systems are at the heart of the right to health and act as a fundamental building block of sustainable development, poverty reduction and economic prosperity (A/HRC/7/11, para. 12). The principles embodied in the Alma-Ata Declaration on Primary Health Care (1978) and the Ottawa Charter for Health Promotion (1986) remain relevant today.

21. The work of the mandate has also addressed the challenges for States in realizing their obligations to ensure that adequate funds are available for health in national budgets, to safeguard an equitable allocation of health resources and to enhance international cooperation to promote sustainable international funding for health (see A/67/302).

22. The work of the Special Rapporteur's predecessors has highlighted that one of most important obligations of immediate effect related to right to health is the duty to avoid discrimination.¹ This means that, even in the presence of resource constraints, that obligation should not be subject to progressive realization. Discrimination and stigma are considered as social determinants in the enjoyment of the right to health, as social inequalities and exclusion shape health outcomes and contribute to increasing the burden of disease borne by marginalized groups. In addition, some health conditions, such as mental health or HIV/AIDS, may involve exposure to compounded forms of discrimination and reinforce existing inequalities (E/CN.4/2003/58, para. 59).

¹ See Committee on Economic Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 43.

23. The work of previous mandate holders has underlined the need to respect, protect and fulfil the enjoyment of right to health and other related rights of those groups who appear to be in vulnerable situations and face discrimination in general, including in accessing health-care services.

24. Previous work on the issue of sexual and reproductive health and rights, including on maternal mortality, has shown that human rights when applied to public health policies can save lives by ensuring that health policies are equitable, inclusive, non-discriminatory, participatory and evidence-based (A/61/338, para. 29). Most of pregnancy-related deaths and many of the causes of under-5 mortality are avoidable. Those most at risk are groups living in poverty, groups in rural areas and women from ethnic and religious minorities or indigenous communities. Women and children must be placed at the centre of an integrated approach to sexual and reproductive health and their rights must be fully recognized.

25. Moreover, the work of the mandate has focused on the serious detrimental impact that the criminalization of identities, behaviours and health status can have on the full enjoyment of the right to health. Criminalization and restrictive laws are ineffective as public health interventions and fuel underreporting of health indicators. For instance, the work done has shown that legal restrictions on access to abortion services, comprehensive sexual and reproductive education and information, and contraception and family planning methods can have a serious detrimental impact on the enjoyment of the right to health. Evidence shows that this includes a negative impact not only on access to goods, services and information, but also on the enjoyment of fundamental freedoms and entitlements, and on the dignity and autonomy of individuals, in particular women (see A/66/254).

26. Previous mandate holders have also looked into the negative impact of the criminalization of consensual same-sex conduct, of sexual orientation and gender identity, of sex work and of HIV transmission (see A/HRC/14/20). Such work has shown that punitive policies and criminalization are not effective and act as a barrier to access health services, fuel social stigma and exclusion and lead to poor health outcomes.

27. On the issue of drug policy, the work of the Special Rapporteur's predecessors has shown that the current international system's punitive regime, which focuses on creating a drug-free world, has failed mostly owing to ignorance of the realities surrounding drug use and dependence (see A/65/255). There is a need for a shift in the current drug control regime away from substance-oriented policies and an increased focus on human rights. Evidence has shown that the criminalization of certain behaviours leads to a reluctance to seek help, including health-related services, and this should be a concern to the authorities. Pursuing overly punitive approaches has resulted in more health-related harms than those the authorities seek to prevent.

28. The important issue of access to medicines has also been part of the work of the mandate. Medical care in the event of sickness and the prevention, treatment and control of diseases depend to a great extent on timely access to quality medicines. Despite progress made, an estimated 2 billion people still lack access to essential medicines. There remains an intrinsic link between poverty and the realization of the right to health, where developing nations have the greatest need and the least access to medicines. Previous mandate holders, including Anand Grover, have given details of the different dimensions of the issues, such as: the role and responsibilities of pharmaceutical companies; the impact of intellectual property laws and free-trade agreements; and the implications and elements of a right-to-health approach to access to medicines (see A/63/263, A/HRC/17/43 and A/HRC/23/42).

29. During the past 12 years, the work of the mandate has also paid special attention to two other key elements of the analytical right-to-health framework: monitoring and accountability. Without monitoring and accountability, all human rights norms and obligations are likely to become empty promises. Accountability in respect of the right to

health and a health system is often quite weak (see A/63/263). Judicial accountability has been highlighted by the work of the mandate (see A/69/299) but other forms of accountability, such as health impact assessments, have also been addressed, including during country visits (Romania, Sweden and Uganda).

30. Other thematic reports have explored the enjoyment of the right to health and the underlying determinants, including water and sanitation, occupational health, the right to health in conflict, unhealthy foods, and the right to health of migrants, older persons and persons with psychosocial disabilities (including the key issue of informed consent).

31. The Special Rapporteur concurs with his predecessors that a comprehensive right-to-health approach is necessary, which includes decriminalization of sexual orientation and gender identities, certain behaviours and health status, as well as the establishment of conducive legal and administrative frameworks with emphasis on human rights education, meaningful participation and empowerment of the groups targeted, and serious efforts to reduce stigma and discrimination in society as a whole.

IV. The way forward: context, challenges and opportunities

32. In the words of Jonathan Mann “the human rights framework provides a more useful approach for analysing and responding to modern public health challenges than any framework thus far available with the biomedical tradition”.² The Special Rapporteur will address the most important issues related to the discharge of his mandate with that in mind.

33. The right of everyone to physical and mental health can only be realized through concerted and sustained efforts, and shared responsibility by all stakeholders at national, regional and universal levels. It requires an unequivocal commitment to the realization of universal human rights principles as enshrined in the Universal Declaration on Human Rights and human rights law and standards.

34. Building on the work of his predecessors, the Special Rapporteur will advocate for the application of the right to health framework to strengthen health systems, emphasizing the need to place the well-being of individuals and communities at the centre of health policies. He will look at processes within health systems — at how things are done and the actors involved — with particular attention devoted to access to information, participation and accountability mechanisms in place (see A/HRC/7/11, paras. 38–64).

35. The Special Rapporteur will continue applying a gender perspective in his work, with a special focus on sexual and reproductive health and rights as an integral part of the right to health. He will apply a life-cycle approach to his work, paying special attention to the needs of the children and adolescents in the realization of the right to health, and the needs of other groups in vulnerable situations, including persons with disabilities. He will continue paying attention to the issue of access to medicines, including access to essential and controlled medicines, and its human rights dimensions.

36. In the current context of the shaping of the Sustainable Development Goals, the realization of the right to health is extremely relevant, both as precondition for, and as an outcome of, a successful process of achieving the Sustainable Development Goals and their main elements.

² Mann, “Health and human rights. Protecting human rights is essential for promoting health”, *British Medical Journal*, No. 312 (1996), pp. 924–925.

A. The policy approach to the right to health

37. There are different and equally relevant ways to apply a human rights-based approach for improving the health of individuals and populations, and to promote the right to health in everyday practices. One such approach is looking at normative frameworks, including at the role of legislation and litigation through courts, which *inter alia* underlines the importance of the justiciability of the right to health.

38. The approach that the Special Rapporteur will prioritize is what he calls the “policy approach”, which focuses on health and health-related policies, including the analysis of processes and outcomes of policies as they are formulated and implemented. It will consider whether or not these policies are based on human rights principles and modern public health approaches, including solid scientific evidence.

39. Departure from universal human rights principles and standards, as enshrined in the Universal Declaration, and from evidence provided by the modern public health approach is a major obstacle for effective realization of the right to health. The Special Rapporteur will use the right to health framework to identify good practices in the operationalization of modern principles of health promotion. He will underline the possible synergies between the human rights and the modern public health approaches for the realization of the right to health worldwide.

40. One of the objectives of the Special Rapporteur will be to examine the “implementation gap”. The human rights-based approach can be very effective in implementing health policies and practices. However, while the fundamental principles and the main processes and mechanisms of the right to health are well identified, there still remains a significant gap between the formulation of health policies and their effective implementation in everyday practice. While the formulation of health policies may be satisfactory from the perspective of the right to health, their effective implementation remains a significant challenge.

41. All too often, the failure to put basic principles into practice is not linked to financial obstacles, but is mostly owing to prevailing attitudes among stakeholders that are not in line with human rights and public health principles. The Special Rapporteur will focus on the “implementation gap” but he will continue to underline, interpret and link the fundamental universal human rights principles and standards with the everyday practice of effective investment in individual and societal health.

42. Despite the work of many who have convincingly highlighted the need and benefits to adhere to universal human rights principles, there continues to be a tendency to apply and justify a narrow and selective approach to human rights, including to the right to health. That tendency has been accentuated during the last decade and questions the very essence of universal human rights principles and standards.

43. For example, such a retrogressive tendency has been observed in the area of sexual and reproductive health and rights, and with regard to discrimination against groups in vulnerable situations, including children, documented and undocumented migrants, persons with disabilities and lesbian, gay, bisexual and transgender persons. In his reports and through his other activities, the Special Rapporteur will highlight the need and importance of applying the principle of the interdependence and indivisibility of human rights, and will underline how essential this is for the full realization of the right to health.

44. The Special Rapporteur is concerned that this tendency to take a selective approach to human rights has its most detrimental effects on those groups of population which face *de jure* or *de facto* discrimination. These groups suffer from social exclusion, stigmatization and humiliation, which has a negative impact to their health status. They are often deprived of access to health support and the care services they need, and of meaningful participation

in processes that affect them. These are the groups in most need of quality and human rights-friendly health-care services precisely because of their situation.

45. This departure from universal human rights principles and this selective approach, ignoring or not adequately addressing one or more rights of a group of the population, reinforces cycles of poverty, inequalities, social exclusion, discrimination and violence, and in the longer run has a negative impact on the health and development of society in general.

46. There are good health practices worldwide that emerge when culturally and socially appropriate programmes are used, involving and empowering individuals, families and communities. These practices challenge traditional barriers between health, education, social welfare and other sectors. For example, effective programmes can be developed to enable community support for preventing violence, particularly violence against women and domestic violence. Community-based initiatives and neighbourhood prevention activities can also be designed to provide education for first-time parents, focusing on child-parent relationships. Support to family planning activities can be put in place to prevent early or unwanted pregnancies through the provision of comprehensive sexuality education and information, and by providing access to a varied range of contraception methods.

47. The cooperation between sectors can also be beneficial to facilitate access to preschool education, especially for children of families at risk, and enable community readiness to accept and integrate children and adults with disabilities into all of the everyday life of the community. This approach can also offer opportunities for adolescents and youth at risk to find alternatives to youth violence by engaging them in community programmes that support recreation centres for older persons, thus contributing to the reinforcement of intergenerational links and improving the quality of human relationships in general.

48. The "policy approach", if implemented effectively, creates valuable opportunities for social innovations through the empowerment of citizens, families, communities and societies at large. By using modern concepts of health promotion and public health, this approach can also facilitate the meaningful participation of all stakeholders and reinforce the protective factors and resilience of individuals and communities.

B. Right to health policies: power asymmetries, unbalanced approaches and other challenges

49. The implementation of evidence-based medicine and public health science is often hindered by the departure from such evidence, resulting in unbalanced and selective policies and practices that hamper the full realization of human rights, including the right to health. One way to analyse the challenges to and opportunities for the effective realization of right to health is to focus on the need to balance the important elements of the right and to prevent tendencies and incentives which lead to power asymmetries and unfair policies and practices.

50. The imbalances in health-related policies and practices are often a result of power struggles and an outcome and sign of a lack of transparency, accountability and political will to follow established principles and standards. Such imbalances emerge often as a consequence of a departure from a holistic approach to human rights. This is reinforced by power asymmetries between stakeholders and interest groups within and outside of health sector. These selective policies and practices tend to lead to ineffective health policies and ineffective, even harmful, health-care practices and to violations of human rights.

51. The Special Rapporteur is concerned about instances of unbalanced policies and practices which seriously undermine the full enjoyment of the right to health. Those imbalances can lead to an artificial hierarchy and a selective approach to human rights prioritizing one group of rights over another, or can set different human rights standards for different groups of the population. Some imbalances and power asymmetries are present within the different elements of health systems; for example, primary care often fails to compete for budget allocations with specialized medicine. These imbalances have also historically led to disparities in investing in physical and mental health.

1. No hierarchy within human rights

52. Lessons should be learned from past and present experiences, which demonstrate that any hierarchy among human rights, a prioritizing of one right or one group of rights over another, leads to detrimental outcomes and systemic violations of human rights. Selective approaches deprive certain groups of basic rights and undermine the meaningful participation and empowerment of all stakeholders. Such participation and empowerment are crucial preconditions for positive public policy outcomes, which are based on the particular attention given to those in vulnerable situations.

53. Many examples have been presented by the health and human rights movement of economic, social and cultural rights being neglected since they were perceived as not requiring immediate action based on erroneous interpretations of the fact that they were subject to progressive realization. That tendency to undermine importance of economic, social and cultural rights has led, and continues to lead, to a detrimental combination of poverty, inequalities and disempowerment of large groups of population, who will consequently suffer from poor health status and barriers to accessing health-care services.

54. The right to health approach, as a part of human rights-based approach, has emerged during recent decades as a powerful tool to reinforce the global goal of improving the health and well-being of populations. However, it can also be used to monitor and prevent those underlying health conditions and tendencies within health-care systems which may lead to violations of human rights and to a negative impact on the health of individuals and societies.

55. In this regard, the Special Rapporteur will continue highlighting the need to reduce poverty and inequalities, including those within and between regions and countries. He will do so by analysing the root causes of the gap between opportunities and reality, between evidence, policies and practices and between obligations of duty bearers and effective implementation.

56. A recent example of the detrimental effect of inequalities has been the Ebola epidemic in countries of Western Africa with weak health-care systems which were not able to adequately respond. One of the lessons learned from that and other epidemics is the importance of social medicine which, since the nineteenth century has highlighted that many diseases and epidemics are social diseases in their origin; therefore, primary prevention should properly address the social determinants of health and the context in which epidemics emerge.

57. The Ebola crisis has provided meaningful lessons with regard to many elements of the right to health. It has questioned our preparedness for emergencies at national, regional and global levels. It has raised important issues, such as access to information, trust in public authorities and safety of medical personnel, and it has reminded us of the importance of upholding the human rights of the affected populations in the context of public safety concerns. The Ebola crisis has once again raised issue of the responsibility and social accountability of key actors, including pharmaceutical companies, and the need for strong public leadership in addressing global health challenges.

58. Another example of an unbalanced approach to human rights is when the full realization of the right to health is hindered by undue restrictions in the enjoyment of civil and political rights. That approach can lead to a failure in the implementation of the principles of participation and empowerment and it undermines the crucial role that civil society can play in promoting societal health and well-being.

59. There is no hierarchy among human rights, and any attempt to restrict or undermine, intentionally or unintentionally, any of the basic human rights can have a harmful impact on individual and societal health and well-being. That is why the best way of "vaccinating" health-care systems and policy decisions against a departure from agreed principles and standards is to systematically apply a human rights approach in full accordance with universal principles enshrined in the Universal Declaration of Human Rights and human rights conventions and treaties.

2. Balancing the key elements in the health-care system

60. All key elements of health-care systems must be balanced. That includes the relationships between the curative and preventive aspects of health care, so that power asymmetries do not weaken primary care and preventive medicine. The modern public-health approach should be strengthened and a right balance between all elements of the health-care system should be ensured so that the implementation of health policies is not dominated by vertical "disease-based" programmes and specialized health-care services.

61. In addition, the role of the health sector and that of other sectors in improving the health of individuals and populations must also be balanced. A modern understanding of the effective realization of right to health requires a "health in all policies" approach. To fully achieve goals, such as to reduce infant or under-5 mortality, improve mental health, reduce the burden of non-communicable diseases or promote the health of older persons, all sectors and all branches responsible for public policies need to be involved.

62. This does not mean that role of health sector should be restricted to specialized health care. On the contrary, the scenario of ministries of health preoccupied mainly with meeting the need of specialized health-care services is an outdated one. The role of the health sector is becoming increasingly important in areas such as health promotion, prevention of health problems and protection of human rights, especially within health-care services, with particular attention given to the situation of marginalized groups. In the promotion of a "health in all policies" approach, the health sector should take the lead and share responsibility for societal health with other sectors.

63. With all this in mind, the Special Rapporteur is considering the analysis of the following themes as some of his priorities.

V. Themes as priorities

A. Global health in the post-2015 agenda

64. The transition from Millennium Development Goals to Sustainable Development Goals is a unique opportunity to rethink achievements and assess the remaining challenges affecting the right to health and well-being of individuals and societies. In the decade between 2000 and 2010, an estimated 3.3 million deaths from malaria were averted and 22 million lives were saved in the fight against tuberculosis. Access to retroviral therapy for

HIV-infected people has saved 6.6 million lives since 1995. At the same time, access to child and maternal health care has improved steadily.⁵

65. Since the end of nineteenth century, science and the practice of medicine and public health have created enormous opportunities for preventing premature mortality and improving the health and well-being of individuals and societies. Many scientific discoveries have been successfully put into practice, resulting in an overall increase of life expectancy, a reduction in maternal and child mortality, a successful combat against many infectious diseases and a general improvement of the quality of life of the world's population.

66. However, current rates of preventable deaths among newborns, children under 5 and adults are still unacceptably high. Universal health-care coverage is still a dream for many. The realization of the right to health is impeded by many factors, and most of them are related to inequalities, and selective approaches to human rights principles and existing scientific evidence. This can and must be addressed with the strong commitment by States and concerted efforts by all stakeholders.

67. In the context of the post-2015 agenda, the right to health framework can be a useful and powerful analytical and operational tool for the transition to the Sustainable Development Goals. And the Sustainable Development Goals can be instrumental for the effective and holistic realization of the right to health, if human rights are effectively incorporated in their conceptualization.

B. The right to health and public policy

68. Primary care is to be strengthened in the twenty-first century as the crucial cornerstone of modern medicine and public health. The Alma-Ata Declaration and Ottawa Charter for Health Promotion should be reaffirmed and the root causes of the relative failure to achieve commitments to "health for all by 2000" should be sought.

69. Without a well-established infrastructure of primary health care, all achievements of modern science and the practice of medicine might be compromised and could be misused. When health policy chooses to prioritize specialized services, the latter tend to function without the necessary ethical and human rights safeguards, leading to barriers in access to services for people and groups who have more health needs or to the ineffective use of those services, or to both.

70. The Special Rapporteur is concerned that primary care and the modern public health approach often lose the battle for resources to the biomedical model and vertical programmes of treatment of diseases through specialized health care. When resources are allocated to specialized health care, that may reinforce power asymmetries and funding imbalances, which often favour powerful groups representing vested interests in the health sector and industry. States, when meeting their obligation to protect, respect and fulfil the enjoyment of the right to health, should be aware of, and be willing and able to address, such power asymmetries. They should also provide mechanisms for independent monitoring, as such mechanisms are essential tools in ensuring accountability.

71. If that does not happen, power asymmetries and imbalances may lead to scenarios where (a) preference in allocating budgets is given to expensive biomedical technologies

⁵ *Millennium Development Report 2014*, quoted in "The road to dignity by 2030: ending poverty, transforming all lives and protecting the planet", synthesis report of the Secretary-General on the post-2015 sustainable development agenda (A/69/700), para. 17.

which are not necessarily used in an ethical and cost-effective way; (b) there are increased incentives for corruptive practices when expensive specialized health-care interventions in public sector do not serve those in most need; (c) the filters (tiers) in health-care systems do not properly function, and mild cases flow into specialized care, placing the entire health-care system at risk of poor management of the principles of medical ethics and health economics. That has negative impact on the full realization of right to health and generates negative public health outcomes.

72. The sustainable implementation of a modern public health approach is not only in line with human rights, but is also a powerful way to develop and strengthen social justice and social cohesion. In that regard, the importance of universal health coverage cannot be overestimated. Since the International Conference on Primary Health Care, there have been many achievements, but also failures. Universal coverage is a central component of healthy public policies and its global achievement should be seen as one of the main goals for the post-2015 agenda. However, the Special Rapporteur thinks that a broader holistic approach is needed so that none, in particular those in vulnerable situations and in most need of health care, are not excluded neither *de jure* nor *de facto* from access to quality services.

73. All international and national actors should be mobilized to reaffirm and revitalize the decisions of the historic International Conference on Primary Health Care and International Conference on Health Promotion. The full enjoyment of the right to health can only be operationalized through human rights-friendly and culturally relevant health promotion policies that empower people to increase control over their lives and improve their health and well-being.

C. Mental health and emotional well-being

74. The historical divide, both in policies and practices, between mental and physical health has unfortunately resulted in political, professional and geographical isolation, marginalization and stigmatization of mental health care.

75. The modern public mental health approach, which emerged in the global scene in the end of twentieth century with a critical mass of new evidence on the importance of mental health and the effectiveness of integrated approaches, still faces enormous challenges. It is regrettable that, in many countries and regions of the world, modern mental health care is still not available. Moreover, in countries which can afford to give resources to mental-health services, those resources are often used to support segregated psychiatric institutions where stigmatizing and human rights-unfriendly services are provided.

76. The Special Rapporteur would like to highlight two key messages of the modern public mental-health approach. Firstly, there is no health without mental health. Secondly, good mental health means much more than absence of a mental impairment.

77. The modern understanding of mental health includes good emotional and social well-being, healthy non-violent relations between individuals and groups, with mutual trust of, tolerance of and respect for the dignity of every person. In that regard, promoting good mental health should be a cross-cutting priority relevant to the sustainable development agenda, as it is of concern to many of its elements, including the protection of dignity and people in order to ensure healthy lives and strong inclusive economies; promote safe and peaceful societies and strong institutions; and catalyse global solidarity for sustainable development (see A/69/700).

78. By investing in the good mental health of children and youth, a substantial contribution is made not only to the sustainable development of our economies, for which good emotional and cognitive abilities are needed, but also the root causes of intolerance and social exclusion are addressed and healthy and cohesive societies promoted.

79. It is estimated that the burden of mental-health problems and mental disabilities constitutes 14 per cent of general burden of disease.⁴ However, compared with physical health, mental health is given inadequately low priority and insufficient human and financial resources.

80. The end of twentieth century brought two main messages to the international community. The first message was about the centrality of mental health in the modern health policies, based on the high burden of mental-health problems and mental disorders. The second message was that, contrary to the previous understanding, effective measures are possible if outdated traditions are abandoned and the modern public health approach is applied. In the twenty-first century there is no place for psychiatric institutions based on stigma and segregation, and there is a need, in words of G.H. Brundtland "to ensure that ours will be the last generation that allows shame and stigma to rule over science and reason".⁵

81. However, after more than a decade since the publication of the landmark *World Health Report 2001*, mental health remains hostage to outdated attitudes and inadequate services. Studies show that, in many instances, there is either no access to mental health services at all, or those services are stigmatizing and violate human rights.⁶

82. One of the significant obstacles to the implementation of modern public mental-health principles is a lack of political will, including on global health agenda, to recognize the centrality of mental health in the full realization of the right to health and to implement the principle of parity between physical and mental health. The Special Rapporteur is concerned that, despite clear evidence of the increasingly heavy burden of mental ill-health, many important stakeholders continue to marginalize this field of health.

83. Mental health deserves much more attention and must be effectively mainstreamed within the Sustainable Development Goals through the goals and benchmarks related to health and sustainable development. The high number of suicides and suicide attempts are an indicator that the mental health of individuals and population needs to be addressed very seriously.⁷ Concerted and effective measures need to be applied to substantively address this challenge and reduce the numbers of suicides, which have in many countries reached epidemic rates. The Special Rapporteur will further analyse the relevance of human rights in addressing suicide and other mental health issues as a public health challenge.

84. In some regions, resources allocated to mental health care are used ineffectively and predominantly for maintaining large segregated psychiatric long-term care institutions and separate psychiatric hospitals. In such institutions, psychotropic medications are too often overprescribed, including as a measure of chemical restraint or even as a punishment. That is an example of an imbalance: when resources are used for biomedical interventions and institutionalization and not for the development of psychosocial interventions through community-based services meeting more closely the individual needs of people. Such imbalances feed ineffective systems, reinforce stigma and social exclusion and lead to systemic violations of human rights, sometimes amounting to torture or ill-treatment.

⁴ WHO estimates available from www.who.int/mental_health/mhgap/en/.

⁵ *World Health Report 2001: Mental Health: New Understanding, New Hope* (Geneva, Switzerland, 2001), p. x.

⁶ Saraceno B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D., Chris Underhill, Ch., "Barriers to improvement of mental health services in low-income and middle-income countries", *The Lancet*, vol. 370 (2007), pp. 1164–1174.

⁷ See WHO, "Preventing suicide — a global imperative" (2014).

85. This, once again, reflects power asymmetries between interest groups behind different forms of services and interventions, and a lack of transparency, monitoring and accountability in mental health-care systems. WHO recommendations are very clear about the five obligatory components of community-based care for persons with severe psychosocial disabilities, which comprise access to psychotropic medications, psychotherapy, psychosocial rehabilitation, vocational rehabilitation and employment and supported housing. However, in many countries, a number of those components are not being implemented.⁸

D. The life-cycle approach to the right to health

86. There is overwhelming evidence that many children die too young from preventable causes and/or suffer high levels of violence and insecurity. Consequently, the health status, quality of life and well-being of many individuals, groups and entire societies worldwide remain unacceptably low. The Special Rapporteur believes that the life-cycle approach can be used as one method to identify the critical elements of the challenges and opportunities for the reduction of preventable deaths and the improvement of health indicators, well-being and quality of life.

87. The Special Rapporteur is planning to address right-to-health challenges using, among other methods, a life-cycle approach. Such an approach helps identify critical elements of challenges and opportunities for full realization of the right to health. It is during some important stages of the life course that the right to health needs to be particularly protected, since during those stages there is a greater risk of violations of human rights, including the right to health. On the other hand, interventions during those critical stages of life open up new opportunities and offer new health protective factors. The life-cycle approach can help in the prevention of chronic diseases in adult life through the effective protection of children from early childhood adversities.

88. In line with the life-cycle approach, the Special Rapporteur will dedicate his next thematic report to the challenges to, opportunities for and best practices in promoting the right to health in early childhood. He will analyse two interdependent and indivisible rights directly related to the right to health: the right to survival and the right to development during first five years of life.

89. The right to survival relates to the prevention of infant and under-5 mortality. Despite many achievements in the field of medicine, 6 million children under 5 die every year in the world. Those children do not die of unknown or incurable diseases or illnesses; they die because of the conditions in which they and their parents live and poor governance and accountability.

90. The launch of the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (A/HRC/27/31) in 2014 is a serious attempt to put an end to the unacceptable epidemics of preventable deaths of infants. The human rights-based approach is critically important in that regard since child mortality is intimately linked with human rights of women and the widespread discrimination against vulnerable groups of population.

91. The right to holistic development is another equally important element of the right to health of children. Children need to be protected through the promotion and protection of their economic, social and cultural rights. Furthermore, from the moment of birth, children

⁸ See WHO, *World Health Report 2001*.

should also be considered as citizens entitled to all rights, including civil rights and freedoms. Their right to health should be promoted not only through the prevention of child mortality and morbidity but also through the protection of children's right to holistic development.

92. The life-cycle approach will be also be used in addressing the right of adolescents and youth to health; the role of family and parenting; mental-health issues and ways to prevent violence as a public health problem; and important issues around healthy ageing.

E. The right to health of persons with disabilities

93. One of priorities of the Special Rapporteur will be to look into the role of the health sector and health professionals in the implementation of ambitious goals raised by the Convention of the Rights of Persons with Disabilities. He hopes to address that role in close cooperation with the Special Rapporteur on the rights of persons with disabilities, and other mandate holders and United Nations mechanisms.

94. The human rights standards set forth by the Convention present a good opportunity to rethink the historical legacy of previous models and to move away from those health-care practices which are against human rights and the modern public health approach. There is a unique and historic opportunity to end the legacy of the overuse and misuse of the biomedical model.

95. All persons with disabilities have a right to health, including to quality health-care services. In that regard, persons with disabilities should not be discriminated against and should enjoy that right in their communities as persons without disabilities do. The Special Rapporteur is concerned that all too often children and adults with different forms of disabilities are deprived of the full realization to the right to health. He will address that serious issue, with a particular focus on the rights of persons with psychosocial and intellectual disabilities.

96. The Convention is challenging traditional practices of psychiatry, both at the scientific and clinical-practice levels. In that regard, there is a serious need to discuss issues related to human rights in psychiatry and to develop mechanisms for the effective protection of the rights of persons with mental disabilities.

97. The history of psychiatry demonstrates that the good intentions of service providers can turn into violations of the human rights of service users. The traditional arguments that restrict the human rights of persons diagnosed with psychosocial and intellectual disabilities, which are based on the medical necessity to provide those persons with necessary treatment and/or to protect his/her or public safety, are now seriously being questioned as they are not in conformity with the Convention.

98. The Special Rapporteur believes that a serious multi-stakeholder dialogue about the future models and practices of psychiatry is needed to address the situation in many countries where exceptions, allowing the restriction of the human rights of service users, sadly turn into rules, and persons with psychosocial and intellectual disabilities suffer from systemic or ad hoc violations of their rights.

99. A large number of persons with psychosocial disabilities are deprived of their liberty in closed institutions and are deprived of legal capacity on the grounds of their medical diagnosis. This is an illustration of the misuse of the science and practice of medicine, and it highlights the need to re-evaluate the role of the current biomedical model as dominating the mental-health scene. Alternative models, with a strong focus on human rights, experiences and relationships and which take social contexts into account, should be considered to advance current research and practice.

100. The issue of shared responsibility is as a crucial one. Representatives of professional health-care groups, including psychiatry, should agree that it is in the interest of all to demonomolize the decision-making process and to develop mechanisms for sharing competences and responsibilities between actors, including providers and users of services, policymakers and civil society.

F. Violence as a major obstacle for the realization of the right to health

101. Protection from all forms of violence is considered by the Special Rapporteur as a cross-cutting issue present in all key elements of the realization of the right to health. As the United Nations High Commissioner for Human Rights has recently underlined, violence and human rights violations are often rooted in the deprivation and discrimination of individuals and communities. Such violations are not generated spontaneously but "result from policy choices which limit freedoms and participation, and create obstacles to the fair sharing of resources and opportunities".⁹ Violence needs to be addressed in a comprehensive and proactive way, not only as a cause of serious violations of human rights, but also as a consequence of a lack of political will to effectively invest in human rights, including the right to health.

102. It was not until the end of the twentieth century that the close link between violence and health began to be sufficiently understood. Interestingly, as health and human rights came closer, a similar tendency could be observed by the turn of century when violence was finally seen as a public health concern. In 1996, the World Health Assembly declared violence as "a leading worldwide public health problem".¹⁰ Since then, the burden of violence has been documented and the effectiveness of programmes, with particular attention devoted to women and children and community-based initiatives, has been assessed.

103. Evidence has shown that, when violence is addressed proactively as a public health issue, there are more opportunities to break the cycle of violence, poverty and helplessness and, in the longer run, to significantly reduce the prevalence of all forms of violence, including collective violence.¹¹

104. All forms of violence are harmful and detrimental to the health and development of human beings, starting from the youngest children. Early childhood adversities, including all forms of violence against children, such as physical and emotional abuse and chronic neglect, if they are not timely addressed by healthy public policies, can result in chronic diseases in the adult affecting both physical and mental health.

105. The human rights approach, together with the modern understanding of public health, warns against typifying violence into severe forms and those forms which are considered to be "milder" and thus perceived as not harmful. That can lead to the proliferation of practices which are justified as being "mild" forms of violence and thus tolerated or even recommended, such as domestic violence against women, female genital mutilation or the institutional care of young children.

106. From the public health perspective, the cumulative effect of a large number of "mild cases" generates a heavier burden for the health of population than a smaller number of

⁹ United Nations High Commissioner for Human Rights, opening speech to the high-level segment of the twenty-eighth session of the Human Rights Council, 2 March 2015.

¹⁰ World Health Assembly resolution 49.25 (1996).

¹¹ See Etienne G. Krug et al. (eds.), "World report on health and violence" (WHO, Geneva, 2002). Available from www.who.int/violence_injury_prevention/violence/world_report/en/

"severe cases".⁴² The practice of tolerating and justifying milder forms of violence can pave the way to severe violations of human rights, which can amount to grave violations and even atrocities.

107. Any form of violence, including collective violence, does not originate in a vacuum. Violence has roots in unhealthy relationships amongst individuals, and is reinforced by the failure to promote and protect good-quality human relations, starting with relationships between an infant and the primary caregiver. The cycle of violence is reinforced when children grow up — whether in families or in institutions — without having their basic needs satisfied, which include not only the need to survive, but the need to feel secure and thus to enjoy the right to healthy development.

108. The most powerful way of preventing the epidemics of violence and different forms of insecurity in the modern world is the provision of holistic support to all forms of family unit, including access to food, shelter, health care and education, but also the provision of basic parenting skills. The quality of relationships between individuals in society is an increasingly important element in the realization of the right to health and the prevention of the cycle of violence. The right to a healthy environment should include not only the physical environment, but also the emotional and psychosocial environment in all settings, family units, schools, workplace, communities and societies at large.

109. The resilience and the protective factors in individuals, families communities and societies need to be promoted, and more investment in healthy human relationships, emotional and social well-being and social capital is required. The empowerment of all stakeholders — without exception — is an effective way of addressing major public health threats and violations of human rights, including the right to health.

G. The role of stakeholders

110. The Special Rapporteur considers the active and informed participation of all stakeholders to be one of the key elements of the analytical framework of the right to health. There is growing understanding and evidence that top-down relations between governments and local authorities and populations, including civil society, and paternalistic relations between health personnel and users of health-care services do not effectively contribute to the realization of the right to health.

111. The meaningful involvement of all actors and the empowerment of those who make use of services, especially the poor and other groups in vulnerable situations, is a crucial precondition for the full realization of the enjoyment by everyone of the right to health and other rights.

112. Civil society actors should be able to do their work for the promotion and protection of human rights, including the right to health, in safe and enabling environments and should not suffer from criminalization, stigmatization or harassment of any sort because of the work that they do (see the report of the Special Rapporteur on the situation of human rights defenders, A/HRC/25/55). The Special Rapporteur believes that there is a clear and direct link between the environment in which civil society operates in a given country and the level of realization of basic rights and freedoms, not only of the public freedoms that are necessary to advocating for human rights, but also of the specific rights for which they advocate. If civil society actors are harassed or persecuted due to their work advocating for

⁴² See Geoffrey Rose, "A large number of people exposed to a small risk may generate many more cases than a small number exposed to a high risk", in *The Strategy of Preventive Medicine* (Oxford University Press, 1992).

and promoting the right to health, that is a symptom of important gaps in the realization of the right itself.

113. It is crucial to strengthen the trust and cooperation between public institutions and those representing the State and civil society actors representing the general public, including the most disadvantaged groups of society. The importance thereof should not be underestimated. Civil society plays a key role as agent of change, advocates good practices, provides independent monitoring and, in many instances, provides necessary services. Trustful partnerships between government agencies, State-run health-care services and the non-profit sector, including civil society, constitute one of the cornerstones of effective health systems and act as a guarantee for the effective realization of health-related human rights.

114. The role of medical doctors and other health-care professionals is also crucial. With the ongoing change of paradigm, from paternalistic top-down medicine to partnership between health-care providers and users, the medical profession should reconsider some of its traditional views. Health-care professionals need to strengthen effective self-regulatory practices and capacity-building activities within their professions so as to promote the best traditions of medicine and prevent ethical misconduct and human rights violations.

115. Education in the health-care sector is one important element in that regard. The doctrine of the "five star doctor"¹³ needs to be reaffirmed in the light of translating modern values and scientific evidence into everyday medical practice. Modern medical doctors need to be not only good clinicians but also effective community leaders, communicators, decision makers and managers. That doctrine should be complemented by a strong human rights-based approach and evidence gained from the modern public health approach.

116. Strengthening the human rights dimension in health-care education curricula would be in the interests not only users of health services but also of medical doctors and other members of the health-care workforce. Medical education, as well as medical and health research, should help in providing tools to address imbalances when power asymmetries lead to too much focus on the tertiary level of health care, biomedical technologies and other components of the excessively exploited biomedical model.

117. The Edinburgh Declaration on medical education¹⁴ should be recalled and education and research reoriented to the basics of social medicine through training in community settings and fostering social sciences and qualitative methods, which are as relevant as biomedical sciences and quantitative research. That would help in restoring the balance with a holistic approach to promoting the health and well-being of individuals and societies.

118. The role of private companies, such as pharmaceutical ones, should also be highlighted. The work of previous mandate holders has been crucial to underline their duties with regard to right to health, in particular the Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines (A/63/263, annex). The Special Rapporteur will be addressing those issues with a view to ending unacceptable practices and entrenched misconceptions.

¹³ Dr. Charles Boelen, "The five-star doctor: An asset to health care reform?" (WHO, Geneva). Available from www.who.int/hrh/en/HRDJ_1_1_02.pdf.

¹⁴ See World Health Assembly resolution 42.39 (1989).

VI. Conclusions and observations

A. Conclusions

119. Over the past few decades, measurable improvements have been made in health indicators and the realization of the right to health worldwide. This has enabled important progress in development goals, and the introduction in many countries of health-related public policies with a human rights and modern public health approach.

120. Moreover, the past 12 years have implied the consolidation of the framework of the right to health, based on the key role of human rights in policymaking. The Special Rapporteur hopes to continue contributing to the full realization of the right to health and related rights by providing guidance on how to address current challenges and how to exploit existing opportunities.

121. States have the primary responsibility to ensure a conducive environment for the full realization of the right to health, and related rights. But the role of other stakeholders is crucial in this respect.

B. Observations

122. In that connection, at the outset of his tenure, the Special Rapporteur would like to put forward the following observations:

(a) Departure from universal human right principles and standards, as enshrined in the Universal Declaration of Human Rights, and from evidence provided by the modern public health approach is a major obstacle for effective realization of the right to health;

(b) History and evidence show that selective approaches to human rights reinforce the cycle of poverty, inequalities, social exclusion, discrimination and violence and are detrimental to the full enjoyment of the right to health;

(c) Inequalities and discrimination remain a crucial factor impeding the full realization of the right to health threatening the healthy development of individuals and societies;

(d) Unequivocal political will to apply human rights principles and standards to normative frameworks and public policies is key in addressing existing imbalances and power asymmetries in the formulation and implementation of health-related public policies;

(e) The meaningful participation and empowerment of all stakeholders should be promoted, in particular of groups in vulnerable situations, and effective monitoring and accountability mechanisms need to be in place to ensure the full realization of the right to health;

(f) The analysis of the functioning and financing of health-care systems, and the need to ensure the right to available, accessible, acceptable and good-quality health-care services remain crucial;

(g) The policy approach, if implemented effectively and creatively, opens up valuable opportunities for social innovations, through the empowerment of individuals, communities and societies at large;

(h) The role of health sector is becoming increasingly important, including for the promotion and protection of human rights, in particular of marginalized groups. The health sector should take the leadership in the promotion of "health in all policies" approach;

(i) Primary care needs to be strengthened as a crucial cornerstone of health system, enabling the effective use of discoveries of modern medicine and public health;

(j) Achieving universal health coverage is one of the main goals and processes for the post-2015 agenda; and commitments made in the Alma-Ata Declaration and Ottawa Charter for Health Promotion should be reaffirmed and revitalized by all stakeholders;

(k) There is no health without mental health. Good mental health means much more than the absence of mental impairment. Modern understanding of mental health includes good emotional and social well-being and healthy non-violent relations between individuals and groups with mutual trust, tolerance and respect of the dignity of every person;

(l) Mental health is relevant to many key elements of the post-2015 agenda and the formulation of the Sustainable Development Goals; and it should be a new priority in public policies addressed in parity with physical health;

(m) The effective promotion and protection of the rights of children and adolescents offers huge potential for the full realization of the right to health in our societies. Synergies between the right to survival and right to holistic development need to drive cross-sectoral policies and accountability mechanisms;

(n) The rights of persons with disabilities are of a special relevance to the right to health and should be protected and promoted through the lens of the Convention on the Rights of Persons with Disabilities. In that regard, the role of health-care services and professionals and the role of the biomedical model need to be reconsidered;

(o) Violence, as a public health problem, needs to be addressed with concerted efforts by all actors as a human rights challenge, having a detrimental impact on the health of individuals and societies. There should be no excuse or justification for any form of violence;

(p) Trustful partnerships between the policymakers responsible for the health sector and civil society actors, including non-governmental organizations, academia and professional associations, constitute one of the cornerstones of effective health systems, and act as a guarantee for the full realization of the right to health and related rights.

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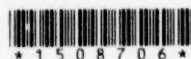
Agenda item 3

**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development****Report of the Special Rapporteur on the right of everyone
to the enjoyment of the highest attainable standard
of physical and mental health, Dainius Pūras****Addendum****Visit to Malaysia (19 November–2 December 2014)****Summary*

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health visited Malaysia from 19 November to 2 December 2015. During the visit, the Special Rapporteur considered, in a spirit of dialogue and cooperation, how the country has endeavoured to implement the right to health. In particular, he assessed issues related to: the health-care system and financing, and the right to health of particular groups, such as women and girls; indigenous communities; migrants, refugees and asylum seekers; lesbian, gay, bisexual and transgender (LGBT) persons; persons living with HIV/AIDS; children; and persons with psychosocial and developmental disabilities.

In the present report, the Special Rapporteur commends Malaysia for its commitment to realizing the right to health, in particular for advances made in reducing poverty, increasing spending on health, and improving basic health-related indicators. For Malaysia to fully realize the right to health, however, the Special Rapporteur encourages the Government to address a number of serious challenges that are mostly connected to a selective approach to human rights and the prevalence of discrimination against groups in vulnerable situations. With a view to facilitating that endeavour, the Special Rapporteur makes a number of recommendations in the report.

* The summary of the present report is being issued in all official languages. The report itself, contained in the annex to the summary, is being issued in the language of submission only.



Annex

[English only]

**Report of the Special Rapporteur on the right of everyone
to the enjoyment of the highest attainable standard of
physical and mental health on his visit to Malaysia
(19 November–2 December 2014)**

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I. Introduction

1. In the present report, the Special Rapporteur gives details of his visit to Malaysia at the invitation of the Government from 19 November to 2 December 2014. The purpose of the visit was to ascertain, in a spirit of dialogue and cooperation, how the country has endeavoured to implement the right to health.
2. During his visit, the Special Rapporteur held meetings with government officials from the Economic Planning Unit of the Prime Minister's Department and the Ministries of Foreign Affairs; Health; Home Affairs; Education; Women, Family and Community Development; Rural and Regional Development, including the Department of Orang Asli Development; Urban Wellbeing, Housing and Local Government; and Human Resources. He also held meetings with representatives of the National Human Rights Commission (Suhakam), civil society and international organizations and development partners, academics, legal experts and health professionals.
3. As part of his visit, the Special Rapporteur visited health facilities in Kuala Lumpur, Melaka and the State of Sabah, including in the Keningau district. He also visited the infirmary of the Kajang Prison (Kuala Lumpur) and two immigration detention centres, the Lenggeng Immigration Depot (Negeri Sembilan) and the Immigration Detention Depot of the Kuala Lumpur International Airport.
4. The Special Rapporteur is grateful to the Government of Malaysia for its invitation and full cooperation during his visit. He would like to take this opportunity to thank the United Nations country team for their support for his visit, and all those who gave him the benefit of their time and experience.

II. Right to health

A. Background

5. The Malaysian economy grew rapidly during the late twentieth century and this growth transformed the country's economic and social landscape. The economy has moved from its initial dependence on natural resources to being dominated by industry and services, and has achieved the status of an upper middle-income country.¹
6. Malaysia has placed the health of its population at the heart of its development policy since it gained independence in 1957. During his visit, the Special Rapporteur commended the Government for its achievements in improving the health status in the country through a sustained commitment to health policy. Considerable improvements have been made in increasing the life expectancy of large sectors of the population. Overall, life expectancy for women has increased from 65.5 to 77 years between 1970 and 2014, and from 61.6 to 72.4 years for men during the same period.
7. Maternal mortality rates have plummeted from 140.8 deaths per 1,000 live births in 1970 to an estimated 25.6 deaths per 1,000 live births in 2012. Infant mortality rates have more than halved during the same period, from 39.4 deaths per 1,000 live births to an estimated 6.3 per 1,000 live births, reaching ratios similar to those of high-income developed countries. Malaysia is one of three countries in the Association of Southeast Asian Nations (ASEAN) with infant and child mortality rates below 10 per 1,000 live

¹ World Bank data, available from <http://data.worldbank.org/country/malaysia>

births. During the same period, the doctor/population ratio has improved from 1 per 4,493 to 1 per 758.²

8. The Special Rapporteur commended the achievements related to some of the underlying determinants of health, including the reduction of poverty, improvements in access to water and sanitation and the effective control of outbreaks of recent epidemics. Malaysia has achieved impressive results in reducing poverty, especially in urban areas, where the percentage of households living in poverty has fallen from 21.3 per cent to an estimated 0.5 per cent between 1970 and 2014.³ However, about 3.4 per cent of rural households still live in poverty.⁴ In this respect, the Special Rapporteur noted with concern stark disparities in the enjoyment of basic health indicators between certain groups of the population, with indigenous and migrants particularly affected.

9. The health sector in Malaysia has developed over the past few decades with a strong focus on primary care and has achieved universal coverage for most of its population, as well as fairly good standards of availability, accessibility, acceptability and quality. Malaysia has also made serious attempts to recognize the challenges of the ongoing demographical and epidemiological transition from a country with a focus on communicable diseases to a country where non-communicable diseases are becoming a concern. These include the National Strategic Plan for Non-Communicable Diseases (2010–2014) and the Non-Communicable Disease Prevention in Community programme.

10. However, many of the challenges that the Special Rapporteur identified during his visit are related to a selective approach to human rights. This approach, mostly based on restrictive interpretations of cultural and religious norms and practices, is a departure from universal human rights principles and standards and has reinforced the exclusion and discrimination, in law or practice, of certain groups from the full enjoyment of the right to health.

11. During his visit, the Special Rapporteur also ascertained the challenges and risks that civil society faces when working on right to health issues, particularly when it comes to exercising the rights to freedom of opinion and expression, and freedom of peaceful assembly. Civil society organizations in Malaysia operate in a very restrictive environment and some work in fear of the application of the Sedition Act 1948. Such an environment precludes the existence of one of the crucial preconditions for the effective realization of the right to health: the participation and empowerment of those affected.

B. International and national legal framework

12. While recognizing the above-mentioned achievements in economic development and improving basic health-related indicators, the Special Rapporteur notes that Malaysia has only ratified three of the international human rights treaties: the Convention on the Elimination of All Forms of Discrimination against Women (1995); the Convention of the Rights of the Child (1995) and the first two Optional Protocols thereto (2012); and the Convention on the Rights of Persons with Disabilities (2010). Malaysia has not extended a standing invitation to the special procedures of the Council although it has invited a number of independent experts to visit the country since 2007.

² Data from the Economic Planning Unit of the Prime Minister's Department.

³ Data from the Macroeconomics Section of the Economic Planning Unit.

⁴ The World Bank, Global Poverty Working Group. Rural poverty headcount ratio at national poverty lines (percentage of rural population). Available from <http://data.worldbank.org/indicator/SP.POV.RUHC>.

13. The accession of Malaysia to these conventions is subject to the understanding that they do not conflict with the provisions of sharia law and the Federal Constitution. Therefore, provisions contained in these core international human rights treaties are not directly enforceable in domestic courts. In addition, Malaysia has introduced reservations to key provisions of the treaties that it has ratified, including article 16 of the Convention on the Elimination of All Forms of Discrimination against Women, which are considered to be part of the core obligations of States parties to the conventions.

14. The Special Rapporteur is concerned about the limited number of international human rights treaties that Malaysia has ratified and the reservations that it has introduced to the conventions mentioned, some of them of a general nature, which seriously undermine the nature and scope of the obligations under those treaties. Moreover, he is concerned that the slow pace of reporting to the monitoring bodies has weakened the accountability of the State and could undermine the efforts undertaken so far.

15. Malaysia has not ratified the 1951 Convention relating to the Status of Refugees and its 1967 Protocol. At the regional level, Malaysia ratified the ASEAN Charter in 2008, which establishes that one of the purposes of ASEAN is to promote and protect human rights and fundamental freedoms, with due regard to the rights and responsibilities of its member States.

16. The Federal Constitution of Malaysia contains a number of provisions for the enjoyment of the right to health, directly or indirectly, most of which are contained in articles 5–13. If these rights are infringed, the victim(s) can seize the High Court Division. Legislation in Malaysia related to the realization of the right to health includes the Penal Code and the Criminal Procedure Code. Also worth highlighting are the Dangerous Drugs Act 1952; the Aboriginal Peoples Act 1954; the Immigration Act 1959/63; the Medical Act 1971; the Drug Dependents (Treatment and Rehabilitation) Act 1983; the Care Centres Act 1993; the Private Healthcare Facilities and Services Act 1998; the Human Rights Commission of Malaysia Act 1999; the Child Act 2001; and the Mental Health Act 2001.

III. Health system and financing

17. In Malaysia, the population has enjoyed relatively high standards of health care at affordable levels owing to the post-colonial, welfare-oriented public administrations' strong commitment to public health care. Since the 1980s, basic public health infrastructure, functioning hospitals, primary care and full-fledged rural health services have all been put in place with particular emphasis on universal health coverage as a hallmark to improve the well-being of the population.

18. However, over the past few decades, Malaysia has witnessed the growth of private health-care facilities and a reduction in the role of the State as health-care provider. Private provision and financing of health care has emerged, in certain sectors, encouraged by public policy. One of the results has been that national health expenses have significantly increased and affordability has become a key challenge in ensuring universal access to quality health care. In 2012, public expenditure accounted for 52 per cent of the total health expenditure, private financing for 39 per cent.

19. The Government has set ambitious goals for the health system in its "Vision for Health", in which it stated that "Malaysia is to be a nation of healthy individuals, families and communities through a health system that is equitable, affordable, efficient, technologically appropriate, environmentally adaptable and consumer-friendly".⁵ The

⁵ Ministry of Health Malaysia, "Strategic Plan (2006–2010)", April 2008, p. 4

health-care system consists of tax-funded and Government-run universal services and a fast-growing private sector. Public sector health services are organized and are centrally administered by the Ministry of Health, which exerts little regulatory power over the private sector.⁶

20. Malaysia is thus facing the complex challenge of sustaining a relatively good health-care system, so that it can continue to provide accessible and affordable primary health-care, as well as specialized outpatient and inpatient medical services. Elements of that challenge include the increased expectations of health-care consumers; the growth of the private sector and out-of-pocket payments in health-care system; the presence of a large population of non-nationals in the working force; and the drain of medical doctors and nurses from public to private sector.

21. The strengths of the health-care system, including the priority given to well-developed and accessible primary care, should continue to be assured and hospitals and specialized outpatient health care developed in a rational and cost-effective way. The Special Rapporteur saw examples of this during his visit, such as the establishment of a widespread network of community clinics, One Malaysia Clinics, and mobile clinics.

22. Public expenditure on health care could and should be strengthened. Overall, the country's expenditure on health has considerably increased over the past few decades, going from 1.3 per cent of the total public expenditure in 2006 to over 8.7 per cent in 2014. However, health-care financing as a share of gross domestic product (GDP) was 4 per cent in 2010 and 4.5 in 2013,⁷ which is low according to international standards and should be increased. As an illustration, this share is lower than the 2010 averages in the Americas (8.1 per cent), Europe (7.4 per cent) and the former Soviet republics (5.7 per cent).⁸

23. According to data available,⁹ of the 2013 total expenditure on health, out-of-pocket expenditure represented about 39 per cent. In many countries, the primary financial barrier to accessing health care is out-of-pocket payments, which are made by the user for health goods and services at the point of service delivery. While in an upper-middle income country, out-of-pocket expenditure could be seen as reflecting the choice and preferences of certain sectors of the population, data available show that, despite universal coverage, 4 per cent of households in Malaysia incur catastrophic expenditures and the two lowest deciles (poorest groups) spend more out of pocket than the eight other deciles in terms of proportion of income.¹⁰ The phenomenon of out-of-pocket payments can have devastating consequences and push into poverty and socially excluded the most vulnerable groups and those who have most serious health needs.

24. In the opinion of the Special Rapporteur, a health-financing scheme should be introduced so that individuals' ability or inability to pay does not affect their decision whether to access the necessary health goods and services. Financial barriers that restrict access to health care, especially for groups in vulnerable situations, should be removed. There should be more integration and cooperation between public and private sectors. All

⁶ Sufurah Jaafar and others, "Malaysia Health System Review", *Health Systems in Transition*, vol. 3, No. 1 (2013, Asia Pacific Observatory on Health Systems and Policies).

⁷ Data provided by Ministry of Health during the visit.

⁸ World Bank, health expenditure, total (% of GDP).

⁹ Malaysia National Health Accounts, "Health Expenditure Report 1997-2013".

¹⁰ Malaysia, Ministry of Health, Household Expenditure Survey (2004), cited in "Country Health Plan, 10th Malaysia Plan (2011-2015)", p. 25.

relevant stakeholders should be involved in the process by means of widespread and effective consultations.¹¹

IV. Groups in vulnerable situations

25. In addition to the challenges mentioned face the health-care system in Malaysia, the Special Rapporteur identified during his visit important barriers to accessing health care, including with respect to accessibility and affordability affecting some groups of the population.

A. The right to health of women and girls

26. During his visit, the Special Rapporteur learned about key initiatives undertaken, mostly since the 1990s, to improve the situation of women in the country. These include programmes to increase their participation in the workforce and in key decision-making positions, such as the National Plan of Action for the Advancement of Women, and programmes to facilitate access to health care, such as the Mammography Subsidy Programme.

27. Overall, girls and women in Malaysia have access to basic (primary and secondary) health-care services and benefit from improved health indicators, including child and maternal mortality, immunization and life expectancy. Maternal mortality rates have been reduced thanks to increased access to professional care during pregnancy, childbirth and postnatal care, and access to family planning services.

28. Malaysia ratified the Convention on the Elimination of All Forms of Discrimination against Women in 1995 but it has neither incorporated the Convention into national law nor effectively introduced gender equality in its legal framework. This, together with the lack of reporting to the Committee on the Elimination of Discrimination against Women and other treaty bodies, makes it very difficult to properly assess the situation and hold the authorities accountable with respect to compliance with international human rights standards related to non-discrimination against women and gender equality.

29. Although Malaysia has consistently reaffirmed the agenda established by the International Conference on Population and Development in Cairo in 1994 and its Programme of Action (E/CN.9/2014/4), many of the goals on that agenda and set in the follow-up to the Programme of Action have not been adequately addressed. While there has been substantial progress in maternal health indicators, more needs to be done to achieve key goals connected to the enjoyment of the right to health of women and girls, in particular concerning sexual and reproductive health and rights, gender-based violence and harmful traditional practices.

1. Sexual and reproductive health and rights

30. During his visit, the Special Rapporteur noted that women and girls face significant barriers to the full enjoyment of their right to health, in particular when it comes to sexual and reproductive health rights.

31. About one third of the population in Malaysia are adolescents and young people, aged from 10 to 24. The Special Rapporteur acknowledges the formulation of the National

¹¹ Suhakam "Report on human rights and access to equitable healthcare" (2011), p. xi.

Adolescent Health Policy and the National Adolescent Health Plan of Action (2006–2020) to ensure coordinated delivery of health-care services to this group of the population.

32. However, the Special Rapporteur is concerned that, on the basis of certain restrictive interpretations of religious and cultural values and beliefs which dominate the political discourse and praxis, women and girls do not always have adequate access to comprehensive sexual and reproductive health services or comprehensive sexuality education.

33. The reproductive health services most needed, in particular among girls and young women, include access to safe, reliable and good-quality contraception; comprehensive maternal health services; safe abortion and treatment for complications of unsafe abortion; and prevention and treatment of sexually transmitted infection and HIV/AIDS (see E/CN.9/2014/4, paras. 68–77). These services should be provided irrespective of age and marital status. Evidence shows that access to comprehensive sexuality education has a positive impact on the knowledge and health-related behaviours of adolescents and youth, especially girls and women, as well as on their attitudes about gender equality (see E/CN.9/2014/4, para. 68).

34. Comprehensive sexuality education is not properly integrated into school curricula in Malaysia. Related educational programmes are often not based on evidence and have a stronger emphasis on abstinence than on providing information and education to girls to allow them to make free and informed decisions about their sexuality. This has contributed to the high prevalence of unintended pregnancies amongst girls, high numbers of underage marriages, unsafe abortions and a high risk of the spread of sexually transmitted diseases, including HIV/AIDS.¹²

35. Therapeutic abortion is available in Malaysia (under article 312 of the Criminal Code) and the termination of pregnancy is allowed under specific circumstances, including for saving the life of the mother, and for physical and mental health reasons. In 2012, the Ministry of Health issued Guidelines on the Termination of Pregnancy, in which it is clearly stated that the termination of pregnancy is legal and a service provided in public hospitals. Despite efforts by the authorities, awareness about the legal status of abortion is not yet widespread, neither among women nor among health professionals. An enabling environment is needed to ensure that every woman legally eligible has access to safe abortion care in Malaysia, including by providing the necessary information and training to relevant health professionals and groups of women at risk and by addressing the stigma associated with seeking abortion services or treatment for abortion complications.¹³

2. Gender-based violence

36. Gender-based violence in Malaysia is considered widespread although underreported, and the scope and enforcement of existing legal provisions remains unsatisfactory. Gender-based violence is an issue of concern for public health and is associated with adverse consequences on the physical and mental health of women affected.

37. Domestic violence was reported to the Special Rapporteur as an issue of concern in Malaysia. Although there is little data available about its incidence, anecdotal evidence points to widespread prevalence of intimate partner violence, and non-partner sexual violence. He commended the Government for the adoption of the Domestic Violence Act (1994) and had discussions with the Ministry of Women, Family and Community

¹² World Health Organization (WHO) Western Pacific Region, *Sexual and Reproductive Health of Adolescents and Youth in Malaysia: A review of literature and projects* (2005), p. 51.

¹³ See WHO, "Safe abortion: technical and policy guidance for health systems", 2nd ed. (2012).

Development about preventing and monitoring domestic violence in the country. The Special Rapporteur emphasized the need to adopt the inter-agency working together document on handling domestic violence cases, in development since 2010.

38. The Special Rapporteur also commended the establishment of One Stop Crisis Centres to provide integrated services for victims in public hospitals. The centres follow a model of multisectoral response to violence against women, involving Government and non-government actors in the establishment of medical, counselling and police services for victims of violence. He visited some of these centres, which are available in most public hospitals. However, he received testimonies indicating that the centres are at times not sufficiently funded or supported with the appropriate human resources.

39. Sexual harassment is not covered in the law in Malaysia. The Code of Practice on the Prevention and Eradication of Sexual Harassment in the Workplace (1999) is not binding and the existing legal framework does not live up to the standards set therein. While the last amendments to the Employment Act (2012) added a new section to address sexual harassment in the workplace, the new provisions omit psychological harassment, only cover strict employer-employee relationships in the private sector, do not protect inter alia students or domestic workers and do not apply to East Malaysia.

3. Harmful traditional practices

40. The Special Rapporteur expressed concern during his visit about the situation of women and girls who face compounded forms of discrimination owing to their social, cultural and religious backgrounds. This includes the prevalence of child marriage among Muslim and non-Muslim girls, and the practice of female genital mutilation or circumcision among Muslim girls.

41. Child marriage is prevalent among certain groups of the population, including both Muslim and non-Muslim children. Malaysian laws set the legal age of marriage at 18 both for females and males but sharia law lowers this to 16 for Muslim females. There are exceptions to these age limits: non-Muslim girls can marry between 16 and 18 years with a licence from the Chief Minister, while Muslim girls below 16 and boys below 18 can marry with the written permission of the sharia court judge.

42. Child marriage is considered a form of forced marriage and has adverse public health-related consequences, which should be of concern for the authorities. Early marriage is often associated with early and frequent pregnancies which result in higher infant and maternal mortality and morbidity rates. In addition, child marriage causes girls to drop out of school and increases the risk of domestic violence, given the subsequent impact on girls' personal and economic autonomy.¹⁴

43. While the Special Rapporteur acknowledges that the incidence of early marriage among girls 15–19 years old has decreased between 1970 and 2010,¹⁵ he remains concerned about its prevalence. Moreover, he is very worried about information received indicating that, in an attempt to reduce the incidence of premarital sex, children born out of wedlock and child abandonment, certain authorities are encouraging underage marriage. This goes against international human rights standards, established by the Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child, and can represent a regression with respect to the Cairo Programme of Action.

¹⁴ See joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women and general comment No. 18 of the Committee on the Rights of the Child on harmful practices (2014), paras. 19–23.

¹⁵ Department of Economic and Social Affairs, World Marriage Data 2012.

44. Female genital mutilation/cutting, which according to various definitions includes female circumcision under type IV,¹⁶ is practised in Malaysia. The Special Rapporteur expressed concern about the prevalence of this practice and learned that the health authorities have produced guidelines to regulate it. He is concerned that this could be contrary to the global strategy against the medicalization of this harmful practice, as established by the World Health Organization (WHO).¹⁷

45. The removal, partially or wholly, of the external female genitalia, or otherwise the injury of female genital organs, for non-medical or non-health reasons, can lead to multiple immediate and long-term health consequences. The Special Rapporteur would like to highlight that this is a form of violence against women and girls, even if not intended as an act of violence, and a violation against their basic human rights and fundamental freedoms, including their right to health. Addressing harmful traditional practices is part of the core obligations of States parties to the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child. These practices constitute a denial of the dignity and integrity of those affected; are based on unacceptable discrimination and violence on the basis of sex, gender, age and other grounds; and often cause severe physical and/or psychological harm or suffering.¹⁸

B. Indigenous communities

46. The indigenous peoples in Malaysia represent around 12 per cent of the total population and include the Orang Asli, or aborigines of Peninsular Malaysia, and the natives of Sabah and Sarawak, also referred to as Orang Asal. The Orang Asli represent about 0.63 per cent of the total population.¹⁹ It is estimated that the natives of Sabah and Sarawak represent about 70 and 60 per cent of the population in the two States, respectively.²⁰ About 60 per cent of the indigenous population live in rural areas, sometimes in remote locations of difficult access.

47. The indigenous communities in Malaysia all have a struggle to preserve their own ways of life based on customary systems (*adat*), constantly under pressure owing to profound changes brought by the rapid economic development in the country. Indigenous peoples are among the most marginalized and disadvantaged groups in Malaysia suffering from higher levels of poverty and social exclusion.

48. Malaysia has endorsed the United Nations Declaration on the Rights of Indigenous Peoples but it has not ratified International Labour Organization Indigenous and Tribal Peoples Convention, 1989 (No. 169). The Aboriginal Peoples Act set forth the rights of the Orang Asli to education, health, socioeconomic development and culture and beliefs. In 2010, the Department of Orang Asli Development was established under the Ministry of Rural and Regional Development to provide protection to this group and their way of life in the wake of rapid development. The Orang Asli Development Strategic Plan (2011–2015)

¹⁶ See WHO, “Eliminating Female Genital Mutilation: An Interagency Statement” (2008).

¹⁷ WHO, “Global Strategy to stop health-care providers from performing female genital mutilation” (2010).

¹⁸ See WHO, “Eliminating Female Genital Mutilation” and “Global strategy to stop health-care providers”. See also joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women and general comment No. 18 of the Committee on the Rights of the Child, paras. 14 and 15.

¹⁹ Data from the Department of Orang Asli Development of the Ministry of Rural and Regional Development.

²⁰ See Suhakam, National Enquiry into Land Rights of Indigenous Peoples, 2013, para. 2.12.

includes such objectives as expanding access to infrastructure, improving health and cultivating traditional knowledge and heritage.

49. Despite commendable efforts by the part of the Government to address health-related issues affecting the indigenous communities, the Special Rapporteur observed that serious challenges remain with regard to their enjoyment of the right to health and related rights, both in peninsular Malaysia and in Sabah and Sarawak. Health indicators among indigenous populations are significantly worse than those of the general population. Their life expectancy is below 60 years, while the average in Malaysia is over 70 years, and they carry a larger burden of disease, both for communicable and non-communicable diseases, including tuberculosis, malaria and leprosy. Infant and maternal mortality rates are higher than the national averages. Birth registration is a serious problem among indigenous communities living in remote areas with a negative impact on access to health care.

50. Access to health-care services for indigenous populations has significantly improved through the development of the infrastructure for health-care services, mostly primary care in remote areas and specialized care, including a hospital for Orang Asli, the Gombak Orang Asli Hospital. Some initiatives, such as "flying doctors" services or the community-based Village Health Promoter Programme, have improved the accessibility of and participation in health-care services by indigenous communities in remote areas.

51. However, health information is not always accessible in a culturally appropriate manner to the indigenous communities, and they are not always properly informed about or involved in public health decisions that affect them. Language continues to be a barrier to accessing health-care services for indigenous communities in the country.

52. Moreover, the right to health of indigenous people is threatened by changes in the use of land caused by development projects linked to logging operations, palm oil plantations and energy-intensive industries in certain parts of the country, in particular in Sabah and Sarawak. This has led to a substantial loss of access to traditional land and sources of livelihood, resettlement processes and instances of violence, which have had a direct impact on the physical and mental health of these communities.

53. During his visit to Sabah, the Special Rapporteur heard testimonies that, as a consequence of ongoing development projects, some of the communities have lost access to traditional lands and sources of livelihood, which has had a negative impact on their diet and physical health. Testimonies also pointed to a lack of meaningful dialogue between authorities and indigenous communities, and these communities do not have access to basic information about the projects in their region and the potential environmental impact.²³ This can have a serious effect on the mental health and emotional well-being of indigenous communities owing to uncertainties about the security of their livelihood in the future, which leads to chronic stress and anxiety.

54. The Special Rapporteur would like to underline that the right to health should be promoted and protected not only through access to health-care services, which should be available, affordable, appropriate and of good quality. The right to health also implies the design and implementation of cross-sectoral programmes that address socioeconomic, cultural and environmental factors and are guided by a human rights approach, with strong emphasis on the principles of non-discrimination, participation and empowerment and accountability.

²³ See Suhakam, National Enquiry into Land Rights of Indigenous Peoples, para. 6.34

C. Migrants, refugees and asylum seekers

1. Documented and undocumented migrants

55. Malaysia is a multi-ethnic, multicultural, and multi-religious society that, owing to its geographical location and economic dynamism, has become a main destination of workers' migratory movements in the region, mostly into low-skilled labour, including domestic work. It is estimated that there are currently over 6 million migrant workers in Malaysia, predominantly from Bangladesh, Cambodia, India, Indonesia, Nepal, the Philippines and Sri Lanka, of whom about 2.9 million are undocumented.

56. Malaysia is a party to five of the eight International Labour Organization core conventions that relate to fundamental principles and right at work. But it has neither ratified the Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87) nor the Discrimination (employment and Occupation) Convention, 1958 (No. 111), and it denounced the Abolition of Forced Labour Convention, 1957 (No. 105) in 1990.

57. The Immigration Act, amended in 2002, and modified by the Immigration Regulations 1963, form the cornerstone of the Malaysian immigration system. In addition, the Passports Act 1966 specifies requirements relating to necessary documentation on entering or leaving Malaysia. Before a work permit can be granted, prospective workers must pass a health check. The Foreign Workers Medical Examination Monitoring Agency manages the health screening system of foreign workers in peninsular Malaysia. Fifteen medical conditions automatically disqualify prospective workers, including an HIV-seropositive status and pregnancy. Workers who are renewing work permits must pass the same health tests.

58. The notification of infectious diseases is required by the Prevention and Control of Infectious Diseases Act, and the Immigration Act is used to deport migrant workers with HIV and/or require them to submit to a medical examination if necessary. This policy and practice poses a serious problem with respect to the right not to be discriminated on the basis of health status, the right to privacy and informed consent. In addition, it goes against international guidelines set out by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO regarding HIV testing.²² Although States may place restrictions on the entry of non-citizens on public health grounds, HIV status is not a reasonable basis for such restrictions.

59. Pregnancy, which is not an illness, also bars migrants from entering Malaysia and, moreover, under current immigration policies a migrant worker who becomes pregnant is subject to immediate dismissal and her work permit is revoked.

60. The Special Rapporteur urges the Government to remove these requirements from the list, both the requirement to be tested for HIV status and for pregnancy. Moreover, both for reasons of public health and to ensure the right to privacy and information, it is essential to ensure that the results of medical examinations are communicated to migrants along with the appropriate health information and counselling.²³

61. Documented migrants, as non-nationals, face specific barriers when accessing the health-care system, which presumes that migrants place a burden on an overstretched public health system. Migrants and foreign nationals have a limit of five days to access medication

²² See UNAIDS/WHO Policy Statement on HIV Testing, June 2004.

²³ See *ibid.*, p. 2.

with a prescription for chronic illnesses, which can have devastating effects on the adequate treatment of some illnesses.

62. Moreover, Malaysia has a policy of double fees, which requires migrant workers, like all foreigners, to pay higher fees. This means, in practice, that migrants admitted to public hospitals pay first-class fees, but are entitled only to third-class treatment. The outpatient fee for migrants in public hospitals, which used to be 2 ringitt (as opposed to 1 ringitt paid by Malaysians) was increased to 15 ringitt in 2004. The Special Rapporteur learned about an initiative in 2014 to increase the fees that migrants and non-nationals pay to access public health care. This can have a catastrophic impact on the enjoyment of the right to health of migrants, both documented and undocumented, given their economic vulnerability and low wages.

63. During his visit, the Special Rapporteur also learned about the establishment of immigration counters inside public hospitals to facilitate referrals of undocumented migrants, which often includes asylum seekers, to the police when they come seeking medical attention. He expressed concern that this practice is not only discriminatory but also goes against public health interests and the code of ethics of doctors. While acknowledging that health-care services are de facto available to migrants, including undocumented ones, the Special Rapporteur warned about the potential adverse impact that the establishment of immigration counters, as undocumented migrants will likely be deterred from seeking health care for fear of being reported. This could have a devastating impact on their health status and could cause the spread of communicable diseases, including HIV/AIDS.

64. In that connection, the Special Rapporteur was alarmed by testimonies during his visit about a wave of arrests of undocumented women migrants and asylum seekers who, a few days after giving birth, had been taken from hospitals directly to detention centres. In those centres, some of these women and their babies had reportedly neither received the necessary medical attention nor the appropriate care needed during the postnatal period.

65. The Special Rapporteur called upon the authorities to ensure that law enforcement officers refrain from using medical procedures and medical care facilities for security and immigration purposes. These policies and practices are intrinsically discriminatory on the basis of legal status and country of origin, can create and reinforce health inequalities and can have serious public health consequences (see A/HRC/23/41). It is therefore vital that the Ministry of Health guarantees access and affordability to adequate health care to all groups in Malaysia, including documented and undocumented migrants.

2. Asylum seekers and refugees

66. Asylum seekers and refugees are by definition groups in a vulnerable situation, given the persecution and violence they have faced in their countries of origin and the risks they face if deported back. At end November 2014, there were approximately 150,460 refugees and asylum seekers registered with the Office of the United Nations High Commissioner for Refugees (UNHCR) in Malaysia, the majority of them from Myanmar, but also from countries such as Iraq, Pakistan, Somalia, Sri Lanka and the Syrian Arab Republic. Of these, approximately 30 per cent are women and it is estimated that about 32,710 were children under 18 years of age.²⁴

67. The vulnerability of this group is exacerbated by the fact that Malaysian law does not provide for the protection of this group, since the country is not a signatory to the 1951 Convention relating to the Status of Refugees or its 1967 Protocol. As a result, asylum

²⁴ UNHCR Malaysia, Figures at a Glance.

seekers and refugees are subject to the Immigration Act as undocumented migrants, and hence are liable to being imprisoned, whipped or removed.

68. There have been some improvements for refugees and asylum seekers in the country recently, and those who have obtained recognition as "persons of concern" from the UNHCR may be able to enjoy a *bas de facto* status at the national level. However, these advances have not been codified into laws or written policies that could provide and ensure an appropriate framework of protection.

69. The health needs of refugees and asylum seekers are complex and require special consideration, given their displacement and relocation. In 2005, the Ministry of Health agreed to provide UNHCR-recognized refugees with a 50 per cent discount on fees charged to non-nationals for health-care services in public hospitals, which includes reproductive health, family planning and immunization. Refugees are recognized as one of the target groups under the National Strategic Plan on HIV/AIDS 2011–2015, which gives them access to treatment and medication and could be considered as a good step.

70. However, while health-care services are available for this group, they are not affordable or accessible, especially for asylum seekers. The cost is prohibitive for asylum seekers, who are required to pay full foreign rates and cannot work to support themselves. The sustained fears of arrest, detention and deportation, exacerbated by the measures described above, deter asylum seekers from seeking medical treatment. Language barriers also act a major obstacle to access vital health-related services and information.

71. Despite the fact that Malaysia has not ratified international standards that protect and promote the rights of refugees and asylum seekers, the principle of non-refoulement is part of customary international law. In addition, Malaysia is bound by the obligations contained in the international human rights treaties that it has ratified which cover the rights of these groups.²⁵

3. Detention conditions in immigration centres

72. Illegal entry and re-entry in Malaysia is punishable with a fine of up to 10,000 ringgit (about US\$ 2,780), imprisonment of not more than five years and whipping of not more than six strokes.²⁶ Existing migration policy, together with the fact that the country does not recognize the special need for protection of refugees and asylum seekers, leads to high numbers of migrants, refugees and asylum seekers in detention, who are exposed to corporal punishment against the universal prohibition of torture and ill-treatment and the obligations of Malaysia under international law.

73. One of the main concerns relating to migrant workers, refugees, and asylum seekers in detention is their mental and physical health needs. Long periods of detention and poor living conditions facilitate the transmission of communicable diseases and can have devastating effects on the mental health of migrants (see A/HRC/23/41, para. 36). This is exacerbated in the case of asylum seekers and refugees, who often suffer from previous trauma from violence, persecution and displacement.

74. Legislation referring to the administration of immigration detention centres includes the Prisons Act of 1995, the Prisons Regulations of 2000 and the Immigration

²⁵ Article 22 of the Convention on the Rights of the Child and general comment No. 6 (2005) on treatment of unaccompanied and separated children outside their country of origin, and general recommendation No. 32 (2014) on the gender-related dimensions of refugee status, asylum, nationality and statelessness of women of the Committee on the Elimination of Discrimination against Women.

²⁶ Immigration Act No. 155, section 6(3).

(Administration and Management of Immigration Depots) Regulation of 2003. Suhakam is the only entity with legal permission to monitor the conditions of detention in these centres, although the International Committee of the Red Cross and UNHCR are allowed to visit on a regular basis. Non-governmental organizations have very limited access to places in which migrants are detained. The Special Rapporteur is encouraged by the fact that the Ministry of Health is now conducting visits on a regular basis to some of the immigration detention centres.

75. The detention conditions in immigration centres have been reported as a source of concern about health (see A/HRC/16/47/Add.2).²⁷ During his visit, the Special Rapporteur had access to the Lenggang Immigration Depot (Negeri Sembilan) and the Immigration Detention Depot of the Kuala Lumpur International Airport (Sepang, Selangor).

76. During his visit to the Lenggang Depot, the Special Rapporteur found out that women who have just given birth are held in a separate area where they have mattresses for them and their babies and are provided with the necessary hygienic products. However, their diet does not seem sufficient for breastfeeding mothers as it was reported that they only get two meals per day. In addition, access to clean water seems to be only upon request and some of these women are reportedly not allowed to spend enough time outside the common cell, including with their babies.

77. In the Lenggang Depot, the Special Rapporteur heard of two cases of migrants held in isolation cells due to mental health issues. He learnt that, in such cases, sufferers do not receive specialized medical attention and one migrants had been in detention for over a year. Both women seemed in good physical condition, but isolation cells are too small and should not be used for the same person for prolonged periods of time.

78. The Special Rapporteur regrets that during his visit to Lenggang he could not finish an interview with a group of women because he was interrupted by an immigration officer arguing security concerns. International standards that apply to monitoring places of detention specify that interviews should be conducted out of sight and earshot of the authorities responsible for the management of the facilities.

79. During his visit to the Immigration Detention Depot of the Kuala Lumpur International Airport, the Special Rapporteur found out that the conditions in the male wards were not up to international standards. Men held there have to sleep on concrete floors, do not always get blankets when the weather is cold and do not have access to soap to wash their clothes. He also found one minor who had been held with adults for more than nine months, and a mental health patient unidentified and not properly treated.

80. In that depot, the Special Rapporteur visited the female ward and met with number of children of Rohingya origin, aged from 4 to 12 years old, who had been held for a period of five to seven months, some of them with special health needs. The detention of children with their parents has a detrimental effect of their physical and mental health and should be avoided; non-custodial alternatives should be explored. A decision to detain migrants who are accompanied by their children should only be taken in very exceptional circumstances and States should always try to preserve the family unit by using alternatives to detaining the entire family (see A/HRC/20/24, para. 40).

81. The right to health requires States to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable groups, as well as to the underlying determinants of health.²⁸ Prisoners and detainees are in a particularly

²⁷ See also Suhakam, Roundtable on Alternatives to Immigration Detention, November 2013, p. 6.

²⁸ General comment No. 14 of the Committee on Economic, Social and Cultural Rights, paras. 35, 36 and 43(a).

vulnerable situation due to their complete reliance on the State for food, shelter, and access to health goods and services.

82. In addition, the Standard Minimum Rules for the Treatment of Prisoners provide for standards related to the availability and accessibility of health care in prisons as well as the underlying determinants of health. The Basic Principles for the Treatment of Prisoners and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment provide for free and non-discriminatory access of prisoners to the same health services available outside the penitentiary system in the place of detention or imprisonment.

D. Lesbian, gay, bisexual and transgender persons

83. Although discrimination on the basis of gender is prohibited in the Federal Constitution (art. 8 (2)), the rights of lesbian, gay, bisexual, and transgender (LGBT) persons are not explicitly recognized. Colonial-era provisions have been retained under the Penal Code and they criminalize sodomy (Penal Code, sects. 377(a) and 377(b)) and perpetuate discrimination against LGBT persons. In addition, discriminatory societal attitudes towards LGBT persons prevail in Malaysia and have been exacerbated over the past few decades by the use of a stigmatizing rhetoric by politicians, public officials and religious leaders.

84. Malaysia has become one of the few countries where transgender people are criminalized. Since the 1980s, a series of legislative initiatives, mostly undertaken under sharia enactments, prohibited "cross dressing" and forced transgender people, who had historically enjoyed a certain degree of acceptance in society, to go underground. In 1982, a fatwa issued by the National Fatwa Council, prohibited Muslims from undergoing sex reassignment surgery and since then very few hospitals have performed such surgery. The National Registration Department does not allow the gender indicator on identity cards to be changed, and this applies both to Muslims and non-Muslims.

85. Some Government institutions have recognized the health needs of transgender persons. The Ministry of Health has included transgender persons and men who have sex with men as a group at risk under the National Strategic Plan on HIV/AIDS 2011–2015, which gives them access to treatment and medication and is a positive step.

86. The criminalization of same-sex conduct and of different forms of gender identity and expression has reinforced negative societal attitudes and has led to serious human rights violations of the rights of this group of the population, including significant barriers in access to health care. Law enforcement officials arrest transgender women and subject them to various abuses, including humiliation in the media, and physical and verbal abuse.

87. Transgender women also face serious discrimination in public health-care facilities. They are often associated with sex work, which is a crime, and they are forcibly tested for HIV/AIDS. They are identified on the basis of their identity card and, unless they have undergone sex reassignment surgery, are often housed in male wards where they can be exposed to violence and abuse. The fear of stigma and discrimination deters transgender women, and other LGBT people, from seeking health care, with the consequent devastating effects that this can have.

88. The Special Rapporteur welcomes the judgement of the Court of Appeal issued on 7 November 2014 that found section 66 of the Syariah Criminal Enactment of Negeri

Sembilan State criminalizing cross-dressing unconstitutional.⁷⁹ The judgement of the Court of Appeal stated that section 66 of the Syariah enactment was not in conformity with the Federal Constitution and violated the rights to live with dignity, equality before the law and non-discrimination, and directly affected freedom of movement and expression. The judgement explicitly acknowledges the profound effect that section 66 has on the appellants who live perpetually at risk of arrest and prosecution simply because they express their gender identity. The Court of Appeal underlined that the existence of a law that punishes gender expression is degrading and deprives those affected of their dignity and value in society.

89. Laws that criminalize same-sex conduct, as well as legal enactments that criminalize transgender women, infringe on the enjoyment of the right to health and other basic human rights (see A/HRC/14/20, para. 6) which are guaranteed by the Federal Constitution and the international treaties that Malaysia has ratified, including the human rights to dignity, equality before the law and equal protection of the law, freedom from discrimination and freedom of expression.

90. During his visit, the Special Rapporteur was also very concerned about information received on programmes and practices supported by public institutions to change the sexual orientation of adolescents, so-called "corrective therapies". Such therapies are not only unacceptable from the human rights perspective but they are also against scientific evidence, and have a serious negative impact on the mental health and well-being of adolescents. State-led programmes to identify, "expose", and punish LGBT adolescents contribute to a detrimental educational environment where the inherent dignity of the child is not respected and discrimination on basis of sexual orientation and gender identity is encouraged.

E. Persons living with HIV/AIDS and drug users

91. The Government is to be commended on measures taken to reduce the spread of HIV/AIDS. As a result, there has been a significant reduction of more than half in new cases, from 28.4 per 100,000 persons in 2002 to 11.42 cases per 100,000 persons in 2012. The number of persons living with HIV in 2013 was estimated at 86,324.

92. Malaysia is a country with a concentrated HIV epidemic, with infection rates that remain high, above 5 per cent, among most-at-risk populations, which include drug users, sex workers, transgender persons and men having sex with men.⁸⁰ Measures have included making available evidence-based treatment, such as antiretroviral treatment and the implementation of harm reduction programmes, most of which have been in place since 2005.

93. Over the past decades, the Government's response has evolved to include the input of a group of stakeholders, including from non-health units within government agencies, civil society actors, private agencies and bilateral and international agencies. In 1992, the Malaysian AIDS Council was established under the auspices of the Ministry of Health to complement the country's responses, with special focus on the most-at-risk populations. This multisectoral and multi-stakeholder response to the pandemic has contributed to achieving positive results.

⁷⁹ Malaysia, Court of Appeal, Civil Appeal No. N-01-498-11/2012.

⁸⁰ See Malaysia, Ministry of Health, "Global AIDS Response Progress Report Malaysia" (2014).

94. Nevertheless, in recent years, Malaysia has seen a surge in HIV/AIDS infections due to sexual transmission, mainly affecting men having sex with men, but now also women.¹¹ The previous success in addressing the epidemic has been somewhat hampered by a lack of full adherence to universal human rights obligations and principles, and the subsequent lack of recognition of the rights of the groups most affected, including LGBT persons.

95. The experience of the HIV/AIDS pandemic has shown that the exposure of vulnerable groups to HIV/AIDS is reinforced through discrimination, stigmatization and disrespect for human rights. Discriminating and ostracizing vulnerable groups will only add to the continuation and further spread of HIV/AIDS. In order to address the increasing rate of sexual transmission of HIV, the Special Rapporteur encourages the authorities to step up their efforts and offer comprehensive sexuality education, which is a key component of the fight against AIDS.

96. Regarding drug policy and the situation of drug users, Malaysia has ratified the three International Drug Control Conventions. The Dangerous Drugs Act describes the punishments for drug-related crimes. Under this act, the possession of 5–15 grams of heroin can result in a life sentence, while possession of more than 15 grams may result in the death penalty. Drug trafficking is also liable to capital punishment.¹²

97. In Malaysia, drug users are forcibly confined to rehabilitation camps, known as Cure and Care Rehabilitation Centres, and receive treatment without their explicit and informed consent. The Drug Dependents (Treatment and Rehabilitation) Act established compulsory drug treatment centres, placed under the supervision of the Ministry of Home Affairs. Upon arrest, drug users undergo drug-use testing. If the test is positive, the person using drugs appears before a magistrate, who can send the user to a drug treatment centre for a period of two years. In these centres, HIV testing is compulsory upon arrival and treatment is mostly abstinence-based, although limited methadone maintenance and anti-retroviral treatments have been introduced. Treatment is still closely supervised by staff, which includes military personnel and security officers, with limited knowledge and skills in health.¹³ According to data available, the relapse rate of drug users held in compulsory detention centres was up to 90 per cent.¹⁴

98. The Special Rapporteur would like to underline that the right to health includes the right to be free from non-consensual medical treatment and requires the informed consent of all who possess legal capacity be obtained prior to the administration of medical treatment (A/64/272). Punitive drug policy regulatory frameworks tend to result in more health-related harms than those they seek to prevent (see A/65/255). A human rights focus on drug policy and control should place the emphasis on voluntary, medically assisted and evidence-based approaches.

F. Children and the right to health

99. The right to health of children has progressed significantly over the past few decades. Malaysia has achieved good results in the area of right to life and survival, reaching and sustaining low rates of infant and children under-5 mortality, and high coverage of child immunization programmes. Recently, there have been effective efforts to

¹¹ International AIDS Society, "HIV and AIDS in Malaysia: Fact sheet", seventh IAS Conference on HIV pathogenesis, treatment and prevention, 30 June–3 July 2013, Kuala Lumpur.

¹² Dangerous Drugs Act, sects. 39(a) and (b).

¹³ WHO, "Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Vietnam" (2009), pp. 19, 26 and 28.

¹⁴ Malaysia Mental Health Association, "Substance abuse — emerging trends (2013)".

prevent non-communicable diseases from childhood, for example by promoting healthy lifestyles and preventing under-nutrition, as well as excess weight and obesity.

100. Malaysia acceded to the Convention on the Rights of the Child in 1995 but still maintains reservations to core articles of the Convention, including articles 2, 7, 14, 28 (1) (a) and 37. As stated above, there remain inconsistencies in the definition of the child in national legislation, both civil and sharia law. The Child Act was enacted in 2001 and the National Child Policy and the National Child Protection Policy, with its Action Plan, were introduced in 2009.

101. Many recommendations made by the Committee on the Rights of the Child in 2007 have not been properly addressed, and important challenges remain, mainly concerning the girl child and children from disadvantaged groups, including indigenous children, children with disabilities, refugee and asylum-seeking children, undocumented migrant children and LGBT children.

102. The Special Rapporteur underlined the lack of recognition of the right of children to holistic development as the main cross-cutting issue. This, in his view, has led to the lack of sustainable policies and measures to promote the emotional and social well-being of children, to protect them from all forms of violence, including sexual violence, and to enhance the ability of parents and teachers to raise and educate children using non-violent methods.

103. The Special Rapporteur identified prevailing attitudes supporting punitive measures for children and the use of violence as a remedy, both in public and private settings. This is reinforced by national and local authorities, for example through the use of corporal punishment in schools, often against LGBT adolescents, which goes against the universal prohibition of torture and ill-treatment. He sees this as a serious systemic issue with a detrimental impact on society's physical and mental health and well-being, ranging from child-rearing practices to public decision-making when addressing social problems.

104. The Special Rapporteur raised the issue of bullying in schools and its detrimental impact on the right to health of children, including mental health. He was encouraged by the reaction of the authorities, acknowledging the problem and underlining their commitment to address its root causes. However, he regrets the absence of modern whole-school approaches that advocate, by educating school communities, zero tolerance of any form of violence. Instead, he had access to information indicating that the approach is, once again, of a punitive nature, offering schools the option of inviting the police to station auxiliary personnel to tackle the issue.¹⁵ The Special Rapporteur urges the authorities to reconsider this initiative, as it will undermine the role of schools as educational institutions and will contribute to perpetuating punitive approaches that do not foster the emotional and social well-being of children in society.

G. Persons with developmental and psychosocial disabilities

105. During the visit, the Special Rapporteur learned about important positive initiatives implemented regarding community-based services for persons with psychosocial disabilities and the integration of psychiatric inpatient units in general public hospitals. He visited a mental health community centre in Putrajaya and was impressed by the approach and the level of the health professionals with whom he met.

¹⁵ Johor Baru, "Police will help schools handle bullies at schools", *The Sun Daily*, 26 November 2014.

106. However, there is still a long way to go in order to achieve the full realization of rights of children and adults with developmental and psychosocial disabilities in the country. Although Malaysia ratified the Convention on the Rights of Persons with Disabilities in 2010, and the Mental Health Act was adopted in 2008, the Special Rapporteur was concerned that certain public policies and services are not in accordance with the Convention's standards. This is connected to the reservations made to the Convention, which limit the application of the core principles of non-discrimination and equality.

107. The infrastructure of user-friendly, community-based services for these groups is not yet well developed, which can lead to systemic violations of their rights, such as right to enjoy living in community and other rights. There are certain initiatives of inclusive education of children with disabilities in mainstream schools but they need further support and development. The Special Rapporteur was concerned about the high prevalence of stigmatization and discrimination of persons living with psychosocial disabilities, which makes it difficult to provide the full spectrum of effective and inclusive community-based services, including health-care services.

V. Conclusion and recommendations

108. The Special Rapporteur notes with appreciation the progress made in Malaysia since independence, in particular, the significant reduction of poverty and the Government's commitment to improving the health of the population. The Government has recognized that the further successful development of the country depends not just on investing in economic growth but also on the social well-being of the population. It has taken steps to improve the well-being of the population, some of which could serve as an inspiration to other countries.

109. However, during his visit, the Special Rapporteur observed deeply entrenched discriminatory attitudes towards groups in vulnerable situations, mostly based on certain restrictive interpretations of culture or religion that discriminate and restrict the rights of these groups, including the right to health. These arguments go against international human rights principles and standards, and when initiated, supported or tolerated by public authorities, they threaten the development of a healthy and inclusive society.

110. Malaysia needs to move away from a selective approach to human rights. The rights of all people living in Malaysia need to be protected, and more efforts are needed to combat the discrimination of the more disadvantaged groups and to achieve their full inclusion in society.

111. The Special Rapporteur recommends that the Government:

(a) Ratify all core universal human rights treaties and the optional protocols thereto, remove all reservations to the treaties ratified and ensure timely reporting to the monitoring bodies; and extend an standing invitation to the special procedures of the Human Rights Council;

(b) Ratify the 1951 Convention relating to the Status of Refugees and its 1967 Protocol in order to ensure adequate protection of refugees and asylum seekers;

(c) Preserve the strengths of the health-care system and ensure adequate, equitable and sustainable financing for health, increase national budget allocations for health and reduce out-of-pocket expenditure;

(d) Ensure that the health system is funded progressively through universal contributions, based on individuals' and families' ability to pay, and that it provides exemptions for the poor;

(e) Ensure that barriers to access sexual and reproductive rights of girls and women in Malaysia are removed, including by providing, regardless of age and marital status, sexual and reproductive health services and comprehensive adequate sexuality education and information;

(f) Adopt the inter-agency "working together" document to handle domestic violence cases", establish the Committee that would implement such guidelines and make sure that civil society actors are well involved;

(g) Adopt a law to prevent and eradicate sexual harassment that effectively protects all men and women from this type of violence;

(h) Ensure that the legal age for marriage is set at 18 years of age, as established in international human rights standards, and do its utmost to eradicate and prevent child marriage and the negative effects it has on the health and well-being of girls;

(i) Harmonize national legislation and customary and religious laws with international human rights standards, and the introduce a legal prohibition of harmful practices, including female genital mutilation or female circumcision, supported by initiatives to prevent and address those practices;

(j) Take the necessary measures so that indigenous communities enjoy their right to health by ensuring access to information and that health services are available, accessible, affordable, adequate and of good quality;

(k) Involve indigenous communities in the health decisions that affect them by consulting them in advance on relevant policies and providing health-related information in a culturally sensitive manner;

(l) Eliminate discriminatory provisions from the foreign workers' health-screening policy and legal framework, including by removing the mandatory test of migrants for HIV/AIDS and the provision excluding pregnant women;

(m) Ensure that non-nationals, in particular undocumented migrants, refugees and asylum seekers, can afford to access public health care, and consider exempting them from the increase in fees;

(n) End the practice of establishing immigration counters in public hospitals, and of arresting undocumented migrant and asylum-seeking women who have just given birth in these hospitals;

(o) Ensure that the conditions of immigration detention centres are up to international standards, and ensure that they are regularly monitored by the relevant authorities and institutions, including the Ministry of Health, Suhakam, the International Committee of the Red Cross, and UNHCR;

(p) Make sure that children are not detained in immigration detention centres, and find suitable alternatives to their detention that preserve the family unit and providing such children with the necessary environment and services;

(q) Decriminalize sodomy and remove any legal provisions that criminalize same-sex conduct and different forms of gender identity and expression so as to guarantee that the existing legal framework is in accordance with the Federal Constitution and international human rights law.

(r) Legally recognize the gender identity of transgender people and prohibit any discrimination on the basis of gender identity in all areas, including health, education, employment and access to public services;

(s) Put an end to State-led programmes that expose and punish LGBT children, and ensure that they enjoy safe and enabling spaces in schools, and other public and private institutions;

(t) Address new trends of the HIV/AIDS epidemic with non-discriminatory policies and comprehensive educational and information campaigns;

(u) Amend the Drug Dependents Act to remove compulsory drug treatment and HIV testing, and make sure that voluntary, medically assisted and evidence-based approaches are used;

(v) Ban corporal punishment in public and private settings, and change the focus of child policies to move away from punitive approaches to promote the well-being and autonomy of children;

(w) Continue developing a system of user-friendly community-based services for children and adults with developmental and psychosocial disabilities, and ensure that the rights of these persons are respected, promoted and protected in accordance with the standards set by the Convention on the Rights of Persons with Disabilities.